

*MISSTREATED: A WOMANIST CLINICAL PASTORAL THEOLOGY ON
AFRICAN AMERICAN WOMEN'S MISTREATMENT IN U.S. HEALTHCARE*

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In Partial Fulfillment
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by
Jessica Chapman Lape

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Doctor of Philosophy

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ABSTRACT

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African American women are mistreated in the healthcare system and have been for generations. "Mistreatment" refers to actions causing emotional, spiritual, or physical harm towards African American women during a healthcare encounter as perceived by the woman receiving treatment. Time is overdue for mistreatment to be interrupted. Any response to address and interrupt mistreatment ought to begin with the stories of the mistreated themselves. This critical narrative inquiry includes the stories, or *living human narratives*, of eight mistreated African American women who from their lived experience, critique and creatively reimagine a healthcare system can survive.

Living human narratives is a womanist reimagination of Anton Boisen's "living human documents." This dissertation constructs a womanist clinical pastoral theology that explores living human narratives through engaging a critical narrative research method. Narrative collection involves transforming the interview into a *boundaried* storytelling space while narrative analysis involves Alecia Y. Jackson and Lisa A. Mazzei's qualitative interpretive method of *thinking with theory*. A womanist clinical pastoral theology begins with listening to the stories of African American women who experienced mistreatment in the American healthcare system. It then interprets the women's stories through two constructed psychoanalytic hermeneutic frameworks: cultural transference-countertransference and womanist

psychospirituality. Finally, womanist clinical pastoral theology provides a response to the mistreatment rooted in the black, ancestral community practice of *birthwork*.

I call out the names Ida, Valeria, Delores, Florence, Helen, Jan, and Carmen.

With gratitude and with love.

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PROLEGOMENON:
A HISTORY OF MISTREATMENT¹

Anarcha's Story

During an Alabama summer in 1845, Anarcha, a seventeen-year-old slave from outside Montgomery, went into labor with her first child. After being in excruciating labor for three days, Dr. James Marion Sims arrived to attend to Anarcha's delivery. Sims brought with him obstetrical forceps, a new and innovative tool he helped to popularize. The forceps entered into and expanded the vaginal canal in the hopes of assisting with a woman's delivery. The forceps worked and Anarcha finally delivered her child, only for them to die soon after. As she lay in recovery for days from her loss and her pain, Anarcha's vagina began to erode due to tears, or fistulas, between her vagina and her bladder and rectum. The fistulas caused constant pain, inflammation, and chronic infections. Urine leaked uncontrollably from her body and an odor constantly surrounded her. Physicians, like Sims, often blamed slaves' gynecological conditions on the incompetence of "nigger midwives." However, vaginal fistulas commonly occurred among all women, particularly following the introduction of forceps into obstetrics. Sims soon realized that perfecting the operation on vaginal fistulas – a now common occurrence – would propel his career and boost his medical reputation. Because Anarcha's condition left her unable to work, Sims approached her owner and requested to rent Anarcha to use her body in a series of experimental operations to discover a reparative procedure.

¹ Content Warning: The Prolegomenon as well as Chapters 4 and 6 contain graphic and unpleasant details of mistreatment including reproductive violation, lack of informed consent, and sexual harassment.

Anarcha was whisked away to Sims' backyard laboratory and over the course of five years, Sims used Anarcha and ten other enslaved women including two named Lucy and Betsey, for countless experimental gynecological surgeries. Colleagues often looked on at Sims' groundbreaking procedures. Undressed, the women would kneel on their hands and knees while Sims used a speculum to open their vaginas for him and other physicians to peer inside. While in surgery, Sims' colleagues would hold the women down, rotating between holding and observing. Sims notably believed black people did not experience pain as compared to whites and refused to provide anesthesia for the procedures he performed. Overtime, however, even his physician colleagues grew disgusted with his work, leaving him to rely on the women to hold one another down, with their bodies writhing in pain. Although he did not anesthetize his victims, he chose to addict the women to morphine – giving them opium only after their surgeries, and using addiction to weaken their ability to resist his horrendously painful operations. Finally, after half a decade and more than thirty surgeries on Anarcha alone, Sims learned to successfully repair vaginal fistulas. In 1852, he published his findings in the *American Journal of the Medical Sciences*, earning him recognition as the “Father of Modern Gynecology” and securing his fame within the white halls of medicine for decades to come.²

A History of Mistreatment among African American Women

Anarcha's screams of excruciating pain are echoed by many African American women fighting for their lives amidst a system not built for their survival. Since African women's forced

² Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (Harlem: Harlem Moon, 2006), 63-66. “Anarcha's Story” is a retelling of Washington's detailed description of Anarcha's life and her role in Dr. Sims' medical research.

arrival to this land, their relationship with American healthcare has often been fraught with mistreatment. This chapter outlines a brief history of mistreatment and introduces a womanist clinical pastoral theological inquiry that attempts to listen to, interpret, and respond to the narratives of mistreatment. For the purpose of this discourse, *mistreatment* refers to *actions causing emotional, spiritual, or physical harm towards African American women during a healthcare encounter as perceived by the woman receiving treatment*. This mistreatment often occurs as a result of the clinician's own cultural location, resulting in conscious or unconscious bias, prejudice, and stereotyping against the African American women they care for. It is easy to identify Anarcha's mistreatment. The physicians' cultural locations were worlds away from her own. She was an enslaved black woman whose body was torn open by a white man tasked with saving her. Sims then took advantage of her tattered body and used it for personal gain. She lacked sedation and anesthesia as she painfully underwent at least thirty intimate procedures while under the gaze of white physicians looking past her humanity. Anarcha's mistreatment was the result of racism, sexism, classism, and ableism that was not only socially acceptable, but was subsequently nationally affirmed and validated.

Black women's bodies have been ferociously studied and abused on slave cabin floors, backyard laboratories, and in state-of-the-art surgery suites for the sake of science and medicine. Black women's bodies have been poked and prodded and pathologized all while their voices, whether screaming in pain or sharing their symptoms, are ignored or not believed. Black women's bodies have been mistreated generations. The lived experiences of enslaved women like Anarcha, Lucy, and Betsey are but opening chapters to long history of mistreatment experienced by African American women throughout the arc of American history. From

Anarcha's womb flows many other stories told by African American women who experienced mistreatment at the hands of clinicians.

Slavery and Southern Medicine

Africans first came to North American shores in the 1600s, a time marked by primitive medical knowledge, a lack of understanding disease processes, and a lack of effective therapeutic treatments.³ Smallpox, tuberculosis, and yellow fever ran rampant throughout new American colonies and on plantations.⁴ Sick slaves were neglected in disease-ridden and non-insulated shacks that served as *slave hospitals* often dying from acute, treatable illnesses.⁵ Despite growth in medical education and technology in Europe, American progress, particularly in the South, lagged decades behind.⁶ Southern medicine continued to lack effective measures for disease prevention and control throughout the antebellum period, particularly with the ever-changing confluence of diseases from North America, Europe, and Africa through the Trans-Atlantic Slave Trade.⁷ For Africans in America, their first experience with non-indigenous healthcare was by being subjected to this uninformed and precarious Southern medicine.⁸ Medical historian, Harriet A. Washington describes Southern medicine as “harsh, ineffective, and experimental by nature.”⁹ Slaves were bought or rented for the intended purpose of medical experimentation and women like Anarcha, Lucy, and Betsey commonly underwent experimental gynecological procedures. Physicians rented enslaved women to not only discover the reparative procedure for vaginal

³ Washington, *Medical Apartheid*, 26.

⁴ Washington, *Medical Apartheid*, 26.

⁵ Washington, *Medical Apartheid*, 29.

⁶ Washington, *Medical Apartheid*, 26.

⁷ Washington, *Medical Apartheid*, 27.

⁸ Washington, *Medical Apartheid*, 27.

⁹ Washington, *Medical Apartheid*, 29.

fistulas, but to perfect both cesarean sections and the ovariectomy.¹⁰ Their mistreatment with healthcare began with negligence in slave hospitals and nonconsensual experimentation.

An outlasting byproduct of Southern medicine is scientific racism, passed as widespread and evidence-based medical and scientific knowledge oft used to justify slavery and racism.¹¹ Such scientific theories were developed out of mythology, racist biblical interpretation, and by cataloging physical racial traits.¹² That African Americans were physically inferior, hypersexual, lazy, and untrustworthy all became engraved in journal articles and medical textbooks as scientific theory based on medical research.¹³ For instance, nineteenth century physician, Samuel A. Cartwright, published many articles on *discovering* a plethora of imaginary “black diseases” such as *hebetude* causing laziness, or *dysthesia aethiopica*, causing a slave to harm or destroy to their owner’s property.¹⁴ He provided owners with torturous “cures” such as whipping and burying alive, prescribed to ensure any slave, infected with an imaginary illness or real, would get back onto the field in no time. Scientific racism sustained these fictitious theories, pathologies, diseases, and cures and continued to be an underlying current within medical research and education for decades.¹⁵

Eugenics and Reproductive Control

The end of slavery ushered in new challenges for African American women and their relationship with healthcare. Washington avers, “During slavery, black women had been forced

¹⁰ Cynthia Prather et al., “Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity,” *Health Equity* 2, no. 1 (2018): 251.

¹¹ Washington, *Medical Apartheid*, 31.

¹² Washington, *Medical Apartheid*, 32.

¹³ Washington, *Medical Apartheid*, 34.

¹⁴ Washington, *Medical Apartheid*, 36.

¹⁵ Washington, *Medical Apartheid*, 36.

to procreate, but now they were being forced into sterility. The consistent factor was white control.”¹⁶ During the Jim Crow era, laws limited access to quality care while experimental medical procedures continued and compulsory sterilizations were commonplace. African American women became entangled in the pseudoscience of American medicine and its obsession with eugenics. Reproductive justice theorist, Loretta J. Ross describes eugenics as “a formal movement launched in the early part of the twentieth century by people who believed they could improve humanity through ‘scientifically’ selective breeding.”¹⁷ “Scientific” rationales were conjured up to deem certain populations as desirable and others as unworthy of reproductive rights. Over time, those deemed undesirable began to include people of color and immigrants, but also mentally and physically disabled people, poor white women, Catholic people, and the imprisoned.¹⁸

By the 1930s, the United States was the first country to legalize mass sterilization in an attempt to “purify the race” and twenty thousand American people were subsequently sterilized without consent.¹⁹ The Negro Project serves as a significant illustration of American healthcare’s attack on African American women’s reproductive health. Best known for her founding of Planned Parenthood and prompting the development of birth-control pills, Margaret Sanger devised the Negro Project to control and reduce black fertility.²⁰ Developed in 1939, the Negro Project “sought to find the best way of reducing the black population by promoting eugenic

¹⁶ Washington, *Medical Apartheid*, 205.

¹⁷ Loretta J. Ross, “Trust Black Women: Reproductive Justice and Eugenics,” in *Radical Reproductive Justice: Foundations, Theory, Practice, Critique*, ed. Loretta J. Ross et al. (New York, NY: Feminist Press at the City University of New York, 2017, Kindle location 1118.

¹⁸ Ross, “Trust Black Women,” Kindle location 1163.

¹⁹ Ross, “Trust Black Women,” Kindle location 1163.

²⁰ Washington, *Medical Apartheid*, 195.

principles” primarily within heavily populated Black communities.²¹ Family planning clinics sprang up in urban neighborhoods to offer contraceptives and other forms of fertility control to poor African American women.²² Many opponents to Planned Parenthood and Sanger’s eugenics ideology claimed that such government-funded clinics and care intended to “limit or even to erase the black presence in America.”²³

In 1961, African American Civil Rights activist Fannie Lou Hamer entered a hospital for the removal of a benign uterine fibroid tumor and left the hospital, unbeknownst to her, with her uterus removed.²⁴ Hamer famously describes her all too common experience as a *Mississippi appendectomy*.²⁵ Through the 1970s, thirty states maintained formal eugenics programs and at many teaching hospitals, medical students used African American women to practice hysterectomies.²⁶ Toward the end of the twentieth century, one-third of all adult women in Mississippi underwent a hysterectomy.²⁷ In North Carolina, sixty-five percent of the state’s sterilization procedures were performed on African American women alone.²⁸ Many African American women were threatened with denial of Medicaid coverage or other medical care if they refused sterilization.²⁹ By 1983, African American women made up forty-three percent of women sterilized through government-sponsored family planning programs despite only making up six percent of the American population.³⁰

²¹ Washington, *Medical Apartheid*, 197

²² Washington, *Medical Apartheid*, 198.

²³ Washington, *Medical Apartheid*, 198.

²⁴ Washington, *Medical Apartheid*, 189.

²⁵ Washington, *Medical Apartheid*, 190.

²⁶ Prather et al., “Racism, African American Women,” 252.

²⁷ Washington, *Medical Apartheid*, 203.

²⁸ Ross, “Trust Black Women,” Kindle location 1141.

²⁹ Prather et al., “Racism, African American Women,” 252.

³⁰ Washington, *Medical Apartheid*, 202.

Mistreatment in Today's Healthcare

From 1998 to 2005, African American women were three to four times more likely to die due to pregnancy-related complications than women of any other race and three times more likely to die in the hospital from reproductive complications than white women.³¹ This trend was apparent for all African American women, regardless of their socioeconomic background or geographic location. In 2017, tennis legend Serena Williams brought the African American maternal mortality crisis to national spotlight. Hours following Williams' delivery of her daughter, Olympia, she alerts medical staff that she needs immediate medical assistance. With a history of blood clots, Williams sensed something was wrong and requested both a heparin drip and CT scan. Her physician refused, assuming Williams was merely influenced by medication. But, Williams persisted. A subsequent CT scan showed several blood clots in her lungs and she finally received the help she advocated for.³² Her experience made national headlines as she spoke to patterns of mistrust toward African American women in maternal healthcare, highlighting the black maternal mortality crisis. Serena Williams was named *Sports Illustrated's* "greatest athlete of all time," and even then, physicians chose not to trust that she knew her own body. Williams' experience ushered in new policy in the state of California that mandates cultural competency training for medical centers with labor and delivery units. But, the COVID-19 pandemic demonstrated that not much has changed for African American women and their reproductive healthcare.

³¹ Prather et al., "Racism, African American Women," 253.

³² Susan Scutti, "After Serena Williams Gave Birth, 'Everything Went Bad,'" CNN.com, accessed January 1, 2019, <https://www.cnn.com/2018/01/10/health/serena-williams-birth-c-section-olympia-bn/index.html>.

Today, in the throes of the COVID-19 pandemic, black birthing people are still two to four times more likely to die from pregnancy-related complications than whites.³³ Fortunately, research shows that the presence of a birthing companion, such as a doula, mitigates pregnancy-related complications.³⁴ However, despite this research, as the pandemic surged in many densely populated urban areas such as New York City, restrictive policies began to emerge barring companions from joining patients during in-hospital labor.³⁵ Many of these policies were rooted in fear and formed with limited data citing the protection of healthcare workers and the preservation of personal protective equipment as the goal of these restrictive measures.³⁶ However, forcing African American women to give birth alone amongst the backdrop of harrowing maternal mortality rates identifies some healthcare systems' low prioritization of the long-term health of African American women and their children. Researchers note the lack of effort in ensuring both reproductive justice for hospitalized birthing people and the safety of healthcare workers during the pandemic.³⁷

African American women's mistreatment extends beyond disparity in reproductive healthcare. Today, black women are twice as likely to die from breast cancer than white women despite both groups receiving mammograms at the same rate. The disparity rests in African American women receiving poorer-quality screenings which contribute to delay in diagnosis.³⁸ Likewise, in mental healthcare, African American women maintain the highest rates of depression and stress in the country. While some literature attests to African American women's

³³ Niles, P. Mimi et al., "Reflecting on Equity in Perinatal Care During a Pandemic," *Health Equity* 4, no. 1 (2020): 330.

³⁴ Niles et al., "Reflecting on Equity," 330.

³⁵ Niles et al., "Reflecting on Equity," 330.

³⁶ Niles et al., "Reflecting on Equity," 331.

³⁷ Niles et al., "Reflecting on Equity," 331.

³⁸ Washington, *Medical Apartheid*, 3.

lack of interest in receiving mental health support in favor of religiosity,³⁹ African American women do prioritize their mental health and seek clinical treatment, but are far more likely to receive poorer quality care, are less likely to receive the sufficient and relevant treatment, and are more likely to terminate treatment early due to culturally incongruent treatment options.⁴⁰ Inadequate screenings, delayed diagnoses, culturally irrelevant treatment, and poor-quality mental health services are mistreatment and this experience is uniquely theirs. Across healthcare systems, trends document that when factors are controlled for education, insurance, and socioeconomics, race remains the sole determining factor for inferior treatment and insufficient care.⁴¹

Throughout the history of the United States, African American women have remained subject to inadequate care, pseudoscience, experimental surgeries, and nonconsensual procedures. In slavery, African American women were left to die in slave hospitals, diagnosed with fictitious diseases, and rented for backyard experiments. Today, African American women are neglected in hospitals, receive culturally incongruent treatment, receive delayed or misdiagnoses, and continue to be more likely to receive hysterectomies for conditions treatable with less invasive procedures.⁴² Examining the history and contemporary experience of mistreatment illumines the messy, abusive, and heartbreaking relationship between African American women and American healthcare. When bodies or minds drag them to the wilderness

³⁹ Chanequa Walker-Barnes, *Too Heavy a Yoke: Black Women and the Burden of Strength* (Eugene, OR: Cascade Books, 2014), 73.

⁴⁰ Thomas G. McGuire and Jeanne Miranda, “New Evidence Regarding Racial and Ethnic Disparities in Mental Health: Policy Implications,” *Health Affairs* 27, no. 2 (March/April 2008): 399.

⁴¹ Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* (New York: New York University Press, 2015), Kindle location 73.

⁴² Prather et al., “Racism, African American Women,” 253.

of healthcare systems, they navigate complex paths. Some make it through the wilderness and find ways to tell their stories.

CHAPTER 1

INTRODUCTION TO THE STUDY

De nigger woman is de mule uh de world so fur as Ah can see. Ah been prayin' fuh it tuh be different wid you. Lawd, Lawd, Lawd!⁴³

African American women experience mistreatment in the American healthcare system. The continued mistreatment across generations is a testament to the endurance of American systems in their foundational quest to destroy the emotional, physical, and spiritual health of African American women and their families. It is also a testament to the endurance of African American women who navigate these wilderness systems and survive. It has been four hundred years since Anarcha's story and the time for mistreatment to end is long overdue.

This is a womanist clinical pastoral theology that constructs a pastoral image of the *living human narrative*, a womanist reimagination of Anton Boisen's "living human document" that theologically explores the lived experiences of African American women mistreated in the United States' healthcare system. Any response to address and interrupt mistreatment must begin with the stories of the mistreated themselves. The living human narratives of mistreated African American women critique systems of oppression that have sought to thwart their flourishing. Living human narratives also creatively reimagine a healthcare system that respects African American women's dignity, humanity, and cultural values. Listening to and exploring African American women's experiences in healthcare provide a strong standpoint when imagining the interruption of mistreatment and a just, safe, and equitable healthcare system for all.

⁴³ Zora Neale Hurston, *Their Eyes Were Watching God* (Urbana, IL: University of Illinois Press, 1978), Kindle Location 564.

Purpose and Research Questions

The purpose of this dissertation is to contribute to the closing chapter of mistreatment by using qualitative narrative inquiry to theologically and psychoanalytically explore eight African American women's stories. Their stories tell not only of their mistreatment in the proverbial wilderness of healthcare, but they tell how each woman made meaning out of her mistreatment and made a way through the wilderness to tell her story. Through collecting these stories of mistreatment and survival, I anticipate a response that reflects the collective wisdom of each living human narrative. I believe a response that begins with the lived stories of "de mule of de world," and their ancestral and lived wisdom, is best suited to disrupt the mistreatment for generations to come. The following research questions frame and guide this qualitative research study:

1. In what ways do African American women experience mistreatment in the American healthcare system today?
2. What occurs within the clinical care encounter leaving African American women with a story of mistreatment?
3. How do African American women make meaning out of their experiences of mistreatment?
4. What is a womanist pastoral theological methodology that best explores African American women's experiences in healthcare?

Research Design

Constructing A Womanist Clinical Pastoral Theological Methodology

This dissertation uses qualitative inquiry to listen to eight women's stories in the American healthcare system and explore mistreatment. Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena⁴⁴ are eight self-identifying African American adult women whose stories tell of the nagging persistence of anti-black and anti-woman bias and prejudice in healthcare systems that follow black women around, weighing them down as they seek treatment. These eight stories are situated in Southern California – from the border towns of San Diego to the rocky shores of Santa Barbara. They take place at different moments in time but are told during a moment in American history where black death, black health, and the American healthcare system are cast as news headlines as if one continuous scroll. Interviews are used to collect narratives, honoring the cultural use of oral-epistemology throughout the African diaspora.

Spirituality is important for African Americans' meaning making processes in the face of health crises and racial discrimination. This use of spirituality to process and cope with both challenging health experiences and harmful racialized experiences affirms that spirituality must be evaluated within research that examines discrimination in healthcare based on race and gender. Womanist clinical pastoral theology provides a praxeological framework to explore African American women's racialized and gendered mistreatment in healthcare. By praxeological, a womanist clinical pastoral theology methodology frames both theoretical and

⁴⁴ The participants' names are pseudonyms and have no identifying markers. The names are of African American women currently leading our national civil rights movement, including the founders of “#SayHerName” and Black Lives Matter, paying homage to African American women presently impacting systemic change in our communities.

practical approaches to engage with living human narratives, an image that describes the lived stories of African American women. For Boisen, listening, interpreting, and responding to “living human documents” are the pastoral caregiver’s primary tasks. This womanist clinical pastoral theology contextualizes the clinical pastoral theological method and listens to, interprets, and responds to the stories of African American women.

I follow this methodology of listening, interpreting, and responding throughout this dissertation. I begin with listening to the stories of African American women who experienced mistreatment in the American healthcare system. I collected these stories through eight individual interviews. I then interpret the women’s stories through two constructed psychoanalytic hermeneutic frameworks: cultural transference-countertransference and womanist psychospirituality.⁴⁵ Finally, I construct a response to mistreatment rooted in the ancestral community practice of *birthwork* in the African American community. Throughout this dissertation, living human narratives are “*listened into life*,”⁴⁶ *interpreted* through contextual psychoanalytic hermeneutics, and *responded to* with practices of justice.⁴⁷

⁴⁵ Lillian Comas-Díaz, “Mujerista Psychospirituality,” in *Womanist and Mujerista Psychologies*, ed. Thema Bryant-Davis and Lillian Comas-Díaz (Washington D.C.: American Psychological Association, 2016), 149-169. I borrow the term *psychospirituality* from mujerista psychology. Lillian Comas-Díaz notes the interdisciplinary aspect of mujerista psychology that engages with a mujerista theology rooted in liberation and feminist theologies. Comas-Díaz acknowledges this interconnection of psychology and contextual theologies as embodied in the critical role of the metaphysical in the inner-world of Latinas/os. She describes mujerista psychospirituality as mujerista’s resistance, wisdom, and agency. I borrow Comas-Díaz’s concept rooted in *mujerismo* and re-appropriate the concept for womanism.

⁴⁶ Marsha Foster Boyd, “WomanistCare: Some Reflections on the Pastoral Care and the Transformation of African American Women,” in *Embracing the Spirit: Womanist Perspectives on Hope, Salvation and Transformation*, ed. Emilie M. Townes (Maryknoll, NY: Orbis Books, 1997), Kindle Location 4758.

⁴⁷ Evelyn L. Parker, “Womanist Theory,” in *The Wiley Blackwell Companion to Practical Theology*, ed. Bonnie J. Miller-McLemore (Malden, MA: Wiley Blackwell, 2014), 207.

This womanist clinical pastoral theology is grounded in both clinical pastoral and communal contextual pastoral theological paradigmatic traditions. These traditions converge to address particularities in the provision of pastoral care for African American women within clinical settings that begins with African American women's lived experiences of mistreatment but also considers the lived realities of the clinicians who cause harm. Sources for this womanist clinical pastoral theology include pastoral theology, reproductive justice theory, womanist and African American psychologies, womanist theology, and black feminist epistemology. The collection of living human narratives begins with listening to African American women's stories through a critical narrative research method involving interviewing for narrative collection and thinking with theory,⁴⁸ for narrative analysis.

My Positionality

I bring to this work experiences in education, clinical chaplaincy, and as an African American woman whose own body is entangled in the American healthcare system. I am from and currently reside in Southern California, but my work begins at a small historically black university (HBCU) in North Carolina, a state I called home for over eight years. In college I majored in community health education, focusing primarily on infant and maternal mortality and preconception health education in African American communities. As a community health educator, I invested in understanding health disparities and the roles of systemic racism and

⁴⁸ Alecia Youngblood Jackson and Lisa A. Mazzei, *Thinking with Theory in Qualitative Research* (London: Routledge, 2012). "Thinking with Theory" is a qualitative analysis method that abandons traditional narrative analysis methodology of coding and producing meaning and rather plugs theory and data into one another to produce new knowledge. Further discussion on thinking with theory takes place in Chapter 3.

generational poverty in health outcomes of African American families. I became immersed in the academic world of public health from a perspective nurtured in African American culture as a student of a historically black university, with black professors, peers, and internship supervisors. This work overlapped with urban ministry as I situated myself in the United Church of Christ, a denomination rooted in social justice. Urban ministry introduced me to intersecting systems of poverty, inadequate healthcare, and environmental racism. Experiences in both reproductive health and urban ministry sparked deep exploration into the intersections of faith, health, and social oppression in the lives of African American women.

While in North Carolina, I began seminary concentrating in “Faith and Health of the Public.” I enrolled in Clinical Pastoral Education (CPE) during my final year of seminary in the hopes to further explore these intersections of faith, health, and racialized and gendered oppression. Around the same time, a formative seminary professor introduced me to the world of doulas and midwifery. I was fascinated by this ancient art of birthwork that resonated with my past work around infant and maternal mortality in the black community. During my CPE internship I played with creative images of spiritual care, exploring womanist images of the chaplain as doula and midwife or conjuring whimsical thoughts of chaplain as witch, shaman, or *bruja*. During my internship, I found Karen B. Montagno’s work paralleling African American pastoral care providers with the Hebrew midwives of Exodus 1, working in the midst of urgency and peril⁴⁹ to save their people from oppressive systems. Imagining black spiritual care providers

⁴⁹ Karen B. Montagno, "Midwives and Holy Subversives: Resisting Oppression in Attending the Birth of Wholeness," in *Injustice and the Care of Souls: Taking Oppression Seriously in Pastoral Care*, ed. Sheryl Kujawa-Holbrook and Karen B. Montagno (Minneapolis, MN: Fortress Press, 2009), 6.

continuing in the sacred legacy of the ancient Hebrew midwives continues to ground my theological framework of my spiritual care practice with African American women in particular.

Ironically, the hospital I trained at held historic ties with North Carolina's federally-funded eugenics program. The hospital's participation in the program publicly ended in the 1970s, however, as I grew to know the large black community surrounding the urban research hospital, I learned many community members still wondered if vague experimentation still happened behind closed doors. Elders in the community regarded the hospital with fear and distrust. The hospital system's state of the art buildings towered over the city's decaying public housing projects serving as sore reminders of the community's violated past. As I continued in that hospital's CPE program as a resident, I simultaneously worshiped and served in a local black UCC church. The elder members of the congregation included physicians and social workers who began clinical practices during the Jim Crow era for the surrounding black community, providing life-saving alternatives to state-funded healthcare services like the aforementioned hospital system. These were black-owned clinical practices emerging as a *response* to the mistreatment occurring right in their backyard. Their stories, wisdom, and perspectives of healthcare, mixed with their enduring expressions of faith in spite of all they witnessed and endured, deeply inform this work.

As a clinical chaplain, I bear witness to the ways faith and spirituality show up in healthcare settings every day, in ordinary ways and in spectacular displays. I bear witness to both the suffering and hope of patients who intimately connect their health and their health's care with their faith, and to families calling out to the divine desperate for miracles or writhing in anger. My role inside healthcare systems also provides me access to spaces where people of color, the poor, non-native English speakers, the undocumented, and those in religious minorities, are often

treated unfairly. Of course, most care providers *treat* patients appropriately, following protocol, compliance guidelines, and using well-informed diagnostics. Most care providers enter into healthcare fields out of a sense of altruism and desire to serve their communities. In my interdisciplinary relationships with diverse care providers, I admire their desires to connect with patients and their families across cultural differences to provide relevant and appropriate care.

I also hear patients get laughed at during morning huddles or watch clinicians smirk when reporting medical histories. Language interpreters are not always used or trauma-informed care is not always applied. In wrestling with this idea of *treating* patients with dignity *and* with medicine, the term, “mistreatment” began to encompass not just overt harm or abuse, but *treating* patients as untrustworthy, with a lack of empathy, or dismissing their story. My work as a clinical chaplain embedded in healthcare systems informs my understanding of just and fair treatment as more than relevant clinical support, but treating patients with trust, patience, and compassionate care.

Finally, I approach this work as an African American woman who relies on the American healthcare system. At times, my mind and my body drag me to the wilderness of healthcare privileging me to the inside of community clinics, fancy exam rooms, and therapists’ couches. Despite my various roles in healthcare systems, I often navigate this wilderness with fear and hypervigilance. I was misdiagnosed and laughed at when explaining behaviors and symptoms. I walked away from appointments ashamed or questioning my own sense of pain. I had headaches blamed on my hairstyles despite my careful recitation of symptoms. My own entanglement with American healthcare and my hope for a future system where I am always believed and my story is always trusted informs this dissertation project. My situatedness in healthcare systems,

womanism, and reproductive justice prepare me to *write for my life* and the lives of other African American women tired of being mistreated.⁵⁰

Rationale and Significance

African American women are disproportionately mistreated in the American healthcare system and this mistreatment is a phenomenon that must be interrupted. It is time for pastoral theology to add its voice and effort to an interdisciplinary disruption of mistreatment among African American women in healthcare. Constructing a womanist clinical pastoral theology contributes to the disruption. Womanist pastoral theology works with the lived experiences of black women and their families who face interlocking systemic oppressions. Clinical pastoral theology examines behaviors and actions of both patient and clinicians within clinical care encounters. These clinical care encounters are often situated within systems perpetuating interlocking oppressions. In my methodological commitment to both frameworks, I use this dissertation to construct an integrated womanist clinical pastoral theology that has the potential to disrupt mistreatment in clinical care settings for African American women. The field of pastoral theology can no longer standby as African American women suffer. We must use our tools and methodologies to contribute to their liberation.

This dissertation seeks to contribute a womanist clinical pastoral methodology to understand the lived experiences of mistreatment in healthcare. This methodology facilitates a theological exploration of lived stories. In doing so, this project reimagines “living human documents” as a womanist image of living human narratives and adopts a clinical pastoral

⁵⁰ Stacey M. Floyd-Thomas, “Deeper Shades of Purple: Womanism in Religion and Society,” in *Deeper Shades of Purple: Womanism in Religion and Society* (New York, NY: New York University Press, 2006), Kindle Location 120.

methodology of listening to living human narratives, interpreting living human narratives, and finally responding to living human narratives with critical frameworks for action and change.

Assumptions

There are two overarching assumptions for this dissertation. This first assumption holds that African American women have a history of mistreatment in American healthcare. The research conducted for this dissertation includes interviews as well as engaging with peer-reviewed journal articles, historical documents, and published texts that outline various ways the American healthcare system has participated in systemic and institutional harm against African American women based on their gender and race. By examining this research, a pattern throughout black women's history in the United States would appear. I name this pattern as "mistreatment," a broad term that encompasses being treated in a way that causes emotional, spiritual, or physical harm. However, other researchers identify this pattern as implicit bias,⁵¹ social control,⁵² and erosion of consent.⁵³

The second assumption holds that mistreatment in healthcare is capable of being examined and disrupted by pastoral theology. I recognize the complexities of not only the American healthcare system but the underlying forces of racism, sexism, ableism, classism, and many others that influence the system in causing harm. Throughout this research, I wrestle with pastoral theology's ability to engage in critical and complex social analysis, but recognize that this field draws upon interdisciplinary resources to support its examination and analysis of

⁵¹ Matthew, *Just Medicine*.

⁵² Ross, "Trust Black Women."

⁵³ Washington, *Medical Apartheid*, Epilogue.

complex systems. The assumption holds that this interdisciplinary discourse framed in pastoral theology proves beneficial to interrupting mistreatment.

Dissertation Chapter Outline

Chapter 2, “Constructing A New Paradigm,” begins with the story of Anton Boisen’s “living human documents” to frame my own re-appropriation, living human narratives. I explore Boisen’s pastoral theological image alongside the clinical pastoral paradigm that dominates methods in theological exploration. I then explore Bonnie Miller-McLemore’s pastoral theological image of the “living human web” alongside the communal contextual paradigm. Womanist pastoral theologies are also discussed as they embrace the communal contextual paradigm, centering the lived experiences of black women. Finally, I construct my own pastoral theological image of the living human narrative as well as a contextual clinical pastoral paradigm to explore African American women’s experience through both intrapsychic and social analysis.

Chapter 3, “Critical Narrative Research,” outlines the methodology used to engage living human narratives. I name and examine three epistemological starting points rooted in theories of reproductive justice, black feminist standpoint theory, and indigenous storytelling. I then outline my critical narrative collection process whereby I attempted to transform the interview into a *boundaried* storytelling space through the process of collective boundary setting. I then outline my critical narrative analysis process and use of thinking with theory to plug in the living human narratives and constructed hermeneutics of cultural transference-countertransference and womanist psychospirituality into one another to see what new knowledge was produced.

Chapter 4, “Listening to Living Human Narratives: Narratives of Mistreatment,” listens to Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena speak for themselves and tell

their stories of mistreatment. The chapter is organized starting with chronic illness diagnosis and management, moves to reproductive and maternal healthcare, and ends with mental healthcare and support. In chapter 5, “Intepreting Living Human Narratives: Hermeneutic of Culture” I think with a constructed theoretical hermeneutic of cultural transference-countertransference. I outline the theoretical concepts and think with the concepts to produce socially constructed images of African American women patients.

Chapter 6, “Listening to Living Human Narratives: Narratives of Meaning Making,” tells eight stories of resilience, spirituality, and self-determination, for making it through mistreatment experiences. This chapter is similarly organized in sections of chronic illness diagnosis and management, reproductive and maternal healthcare, and mental healthcare and support. Chapter 7, “Intepreting Living Human Narratives: Hermeneutic of Psychospirtuality,” outlines the constructed theoretical hermeneutic of womanist psychospirituality and explore the women’s use of spirituality to cope, shape healthcare values, and *make a way out of no way*.

In chapter 8, “Responding to Living Human Narratives: Birthwork is Spiritual Care,” articulate eight *calls-for-response* rooted in the women’s narratives. This use of call-and-response discourse centers the women’s calls for both providers and African American women patients as they navigate the healthcare system. I further discuss how the critical narrative research process with living human narratives “made and unmade”⁵⁴ me as I dove into black birthwork and expanded my understanding of pastoral care. I use my experience and new knowledge of black birthwork to respond to living human narratives of mistreatment and invite further exploration of black birthwork as spiritual care operating within the contextual clinical pastoral paradigm.

⁵⁴ Jackson and Mazzei, *Thinking with Theory*, 137.

Finally, chapter 9, “Summary and Next Steps,” provides a summary of the eight living human narratives as well as summarizes this dissertation’s key contributions to clinical pastoral theological theory and method. It suggests next steps for pastoral theology to participate in the interruption of African American women’s mistreatment.

CHAPTER 2

CONSTRUCTING A NEW PARADIGM

Metaphorical images are often used in pastoral theology to capture the expansiveness and creativity of pastoral care and counseling. These images not only help to frame the role and task of the pastoral care provider, but as Robert C. Dykstra describes, these pastoral images “foster a richer sense of pastoral self-understanding, identity, and integrity.”⁵⁵ Pastoral images also provide metaphorical interpretations of pastoral theological paradigms. Pastoral theological paradigms are inter-relational approaches to exploring lived human experience each with their own theological objectives. Anton Boisen’s 1936 pastoral image of the living human document is noted as a classical image of pastoral care rooted in the clinical pastoral paradigm, a dominant framework for theologically engaging with lived experience. The clinical pastoral paradigm is a foundational perspective for pastoral theology, care, and counseling and continues to shape CPE curricula – the primary training mechanism for pastoral care providers. The clinical pastoral paradigm focuses on individualistic clinical care that explores human experience by investigating the inner worlds of those receiving care through intrapsychic analysis. The theological objective of the clinical pastoral paradigm is to liberate care receivers from their bondage to spiritual and psychological struggle.⁵⁶

In her feminist response to Boisen’s living human documents and the clinical pastoral paradigm, Bonnie J. Miller-McLemore constructed the “living human web,” a pastoral

⁵⁵ Robert C. Dykstra, “Introduction,” in *Images of Pastoral Care: Classic Readings*, ed. Robert C. Dykstra (St. Louis: Chalice Press, 2005), 13.

⁵⁶ Nancy J. Ramsay “A Time of Fervent and Redefinition,” in *Pastoral Care and Counseling: Redefining the Paradigms*, ed. Nancy J. Ramsay, (Nashville: Abingdon Press, 2004), 10.

theological image rooted in the communal contextual paradigm. This paradigm focuses on communities as responsible agents of care and explores human experience through engaging in critical social analysis. It relies on transdisciplinary methods to engage human experience beyond inner worlds. It takes seriously the social and political context of the care receiver and care provider and finds community, rather than individualistic care, to play an integral role in interpersonal exploration. The theological objective of the communal contextual paradigm is to liberate those stuck in the confines of social oppression.⁵⁷

This chapter proposes a new paradigm, one that appreciates and blends clinical and contextual approaches. This contextual-yet-clinical pastoral approach focuses on individualistic clinical care and explores human experience by investigating inner worlds. However, the paradigm also engages deep social analysis and considers the cultural situatedness of both the care receiver and care provider. This new paradigm's theological objective avoids the idea of *liberating from* spiritual struggle. The women I interviewed demonstrated no need for liberation from spiritual struggle but rather demonstrated spiritual and theological resilience as they made meaning out of their experiences. While liberation from social oppression is a theological objective with deep resonance to communities of color, this contextual-yet-clinical pastoral paradigm recognizes that liberation from social oppression is reactionary at best, and an inconsistent message when joined with no action to dismantle systems drenched in injustice, inequality, and white supremacy.

There is no way to untangle the American healthcare system – or any American system – from social oppression. There is no American healthcare system free from the legacy of Anarcha and Fannie and Serena. And, there is no way to untangle African American women from their

⁵⁷ Ramsay, “A Time of Fervent and Redefinition,” 10.

reliance on healthcare. They have the right to receive emergency medical care, chronic illness management, or preventative treatment such as vaccinations or birth control. African American women must continue to access healthcare systems despite how unjust or socially oppressive the system may be. The communal contextual paradigm's goal for liberation from social oppression is a bold theological objective that must also be joined with critiquing systems of social oppression and reimagining these systems to support social flourishing. A contextual-yet-clinical pastoral or *contextual clinical pastoral paradigm* reaches beyond the call to liberate *from* – because where else would they go? – and sets critique and reimagination as its theological objective. This chapter discusses the clinical pastoral paradigm and its complimentary pastoral image of the living human document as well as the communal contextual paradigm and the living human web. I then situate current womanist pastoral theologies on this pastoral paradigmatic continuum and introduce a contextual clinical pastoral paradigm and the pastoral image of living human narratives to engage a womanist theological exploration of African American women's lived experience in the clinical pastoral setting.

Clinical Pastoral Paradigm and The Living Human Document

Anton Boisen's image of the living human document is a classic illustration of the clinical pastoral paradigm. Following his own stay at a psychiatric hospital, Boisen theorized that many psychiatric patients experience a religious crisis of their inner world that precipitates their mental illness. In a 1921 letter, Boisen writes, "I feel that many forms of insanity are religious rather than medical problems and that they cannot be successfully treated until they are so

recognized.”⁵⁸ After his discovery and release, Boisen searched for a hospital chaplaincy position, but soon realized none existed. Desperate to test his theory, Boisen finally found work at the Boston Psychopathic Hospital where he had the opportunity to study patients’ inner experiences.⁵⁹ Boisen contends that because the purpose of his inquiry was to help the patients he studied, they were eager and willing to share, opening up to him their inner worlds.⁶⁰ Eventually, Boisen’s study led him to experiment with bringing theological students to study patients in hospitals.⁶¹ In the role of patient attendants, students were “provided an unequalled opportunity to observe and understand the patient.”⁶² Boisen’s theological students explored human experience through investigation of psychological and spiritual struggle.

Boisen grew concerned with ensuring a continuous connection between theological education and the language world of human experience.⁶³ The image of the living human document metaphorically positions human experience as sacred Judeo-Christian text.⁶⁴ Charles Gerkin attests to Boisen’s attempt to assign a living human document “authority and right to speak on its own terms” and the respect to be authentically heard.⁶⁵ The concept of the living human document privileges the language world and personal experience of the person sharing their story. Boisen argued that inner world of patients struggling with their mental and spiritual

⁵⁸ Anton T. Boisen, “The Living Human Document,” in *Images of Pastoral Care: Classic Readings*, ed. Robert C. Dykstra (St. Louis: Chalice Press, 2005), 26.

⁵⁹ Boisen, “The Living Human Document,” 28.

⁶⁰ Boisen, “The Living Human Document,” 28.

⁶¹ Boisen, “The Living Human Document,” 28.

⁶² Boisen, “The Living Human Document,” 29.

⁶³ Charles V. Gerkin, “Reclaiming the Living Human Document,” in *Images of Pastoral Care: Classic Readings*, ed. Robert C. Dykstra (St. Louis: Chalice Press, 2005), 33.

⁶⁴ Gerkin, “Reclaiming the Living Human Document,” 34.

⁶⁵ Gerkin, “Reclaiming the Living Human Document,” 35.

health deserve the same respect, understanding, and interpretation as sacred texts, and encouraged his students to read living human documents as first-hand sources of human nature.⁶⁶

Boisen's concept of the living human document was not born to consider the multivariate systems that produce human suffering. Much historical analysis of Boisen's work takes places against the backdrop of pastoral theology and psychological theory. However, the American healthcare system, including psychiatric hospitals, also warrants similar inquiry. Boisen began his exploration of patients' inner world in the mid-1920s, during the height of the United States' mass eugenics movement. The pseudoscience of eugenics hinged upon the prevention of undesirable traits from being hereditary and those with disabilities, cognitive and physical, were particularly targeted for eugenics study. Although, on record, sterilizations were not legalized in the state of Massachusetts, the founding director of the Boston Psychopathic Hospital, Elmer Ernest Southard, was a known American eugenicist. Shortly after the Boston Psychopathic Hospital was founded, Southard joined the inaugural Board of Scientific Directors of the Eugenics Record Office based in Washington D.C. There, he secured funding for the study of the insane in the Boston area and lobbied for increased eugenics studies in the state of Massachusetts.⁶⁷ Much like the entire American scientific world, eugenics ideology permeated the very founding bricks of many psychiatric hospitals. Boisen's living human documents were patients likely treated by clinicians engaging with eugenics ideology, benefitting from the funding that Southard secured.

⁶⁶ Boisen, "The Living Human Document," 29.

⁶⁷ "Eugenics Record Office," *Image Archives of the American Eugenics Movement*, accessed September 1, 2020, http://www.eugenicsarchive.org/eugenics/topics_fs.pl?theme=20&search=&matches.

The image of the living human document is a clinical pastoral paradigm of pastoral theology, care, and counseling. Boisen's work is the result of his social location in the early-twentieth century healthcare and Protestant religious system that held little and inconsistent conceptual frames for acknowledging systems of oppression such as ableism in the investigations of a person's inner world. The concept of the living human document emerged in a time when clinical patients and African American communities were often studied like objects and Boisen's work benefitted from this objectifying gaze.

The clinical pastoral image of the living human document neglects to examine political and social aspects of lived experience beyond the immediate context.⁶⁸ Boisen searched for disruptions, not in his patients' world of pseudoscience and ableism, but in their religious experience as interpreted through the lens of European American psychoanalysis. The theological study of human experience must take into consideration the social, cultural, and political background of the investigators of human experience, the subjects of investigation, and the system in which the investigation takes place. In Boisen's case, the image of the living human document focuses on unpacking the immediate experience of medical or psychological crises but neglects constructing a critical analysis of the cultural context of the living human document. It also neglects constructing a critical analysis of the medical system in which the living human document and their reader participate.

Communal Contextual Paradigm and The Living Human Web

Bonnie Miller-McLemore's image of the living human web, a communal contextual paradigm, juxtaposes Boisen's clinical pastoral living human document. A term proposed by

⁶⁸ Ramsay, "A Time of Fervent and Redefinition," 9.

pastoral theologian John Patton, the communal contextual paradigm of pastoral theology, care, and counseling focuses on the care of entire faith communities rather than individualized clinical care of the clinical pastoral paradigm and acknowledges the importance of cultural, social, and political locations in the role of human experience.⁶⁹ Miller-McLemore's communal contextual paradigm suggests adopting an image of interconnectedness – a living human web – that takes seriously the sociocultural analysis of power and its impact on a person's inner world. She argues the individualistic aspect of pastoral care relies too heavily on psychology as a major tool for interpretation.⁷⁰ The use of alternative interpretative methods, such as other social sciences, expands interpretation by addressing complex social systems' impact on the psyches of human beings.⁷¹ Within a living human web, care providers acknowledge cultural location, race, gender, and the interwoven systems of oppression that impact flourishing.

The communal contextual paradigm embraces critical pastoral theologies such as feminism and womanism. Miller-McLemore's living human web is a feminist approach and constructs a critical analysis of the "individualistic focus of pastoral care" as well as critiques clinical pastoral paradigm's lean toward psychoanalysis as the only method of exploring women's experience.⁷² Miller-McLemore writes, "In a word, never again will a clinical moment, whether of caring for a woman recovering from a hysterectomy or attending to a woman's spiritual life, be understood on intrapsychic grounds alone."⁷³ The communal contextual paradigm encourages multivariate methods to explore the human experience beyond

⁶⁹ Ramsay, "A Time of Fervent and Redefinition," 11.

⁷⁰ Bonnie J. Miller-McLemore, "The Living Human Web," in *Images of Pastoral Care: Classic Readings*, ed. Robert C. Dykstra (St. Louis: Chalice Press, 2005), 43.

⁷¹ Miller-McLemore, "The Living Human Web," 40.

⁷² Miller-McLemore, "The Living Human Web," 43.

⁷³ Miller-McLemore, "The Living Human Web," 43.

psychoanalysis, including those rooted in cultural and communal identity. While I agree women's experience cannot be "understood on intrapsychic grounds alone," I believe psychological inquiry to be imperative to exploring human experience. In addition to transdisciplinary methods to support a full spectrum inquiry into human experience, pastoral theological paradigms must locate critical psychological approaches to support intrapsychic inquiry that considers social and cultural context.

Furthermore, in communal contextual paradigms, faith communities, not individualized care, are spaces for healing and transformation. Care is viewed as the responsibility of an entire ecclesial community rather than sole the responsibility of clergy.⁷⁴ Outside of a clinical setting, communal ritual may resonate with communities of color. However, for this pastoral theological inquiry, I explore human experience in the clinical setting and construct a pastoral theological response to a clinically situated phenomenon. Rather than citing faith communities as privileged spaces for pastoral theological inquiry, I privilege the potential of individualized clinical inquiry in investigating lived human experience.

Womanist Pastoral Theologies

Shortly following Miller-McLemore's feminist critique of the clinical pastoral paradigm, womanist pastoral theologians including Marsha Foster Boyd and Carroll A. Watkins Ali critiqued the clinical paradigm as it relates to African American women. They constructed communal contextual pastoral theologies that depart from the clinical pastoral paradigm. Then follows Phillis Isabella Sheppard and Stephanie M. Crumpton who adopt aspects of both clinical pastoral and communal contextual paradigms in their pastoral theologies. Exploring these

⁷⁴ Ramsay, "A Time of Fervent and Redefinition," 11.

womanist pastoral theologies amongst the backdrop of pastoral paradigms helps to find spaces to expand contextual pastoral theological inquiry, particularly as it relates to African American women.

Communal Contextual Paradigms:

Shifting Away from Clinical Models of Care

Marsha Foster Boyd describes her womanist pastoral theology as WomanistCare. For Foster Boyd, “WomanistCare is the intentional process of care giving and care receiving by African American women.... In this process, the focus is the holistic care of body, mind, and spirit in order that healing and transformation occur for African American women and their circles of influence.”⁷⁵ Foster Boyd finds common clinical pastoral images such as *shepherd*, *wounded healer*, and *servant* to be problematic for black women caregivers as black women are often historically relegated to servant roles within society.⁷⁶ Rather than use these loaded images, Foster Boyd embraces the term *empowered cojourner*.⁷⁷ The empowered cojourner is an empathic presence with an awareness of black women’s struggle. Foster Boyd writes, “This image of the cojourner encourages us to work and walk together; and as we work and walk together, our community, our family, and our selves as individuals are able to be transformed.”⁷⁸

Foster Boyd further describes WomanistCare as generally provided within “small group settings, be they secular or spiritual,”⁷⁹ thereby situating WomanistCare as a communal contextual pastoral paradigm. Foster Boyd explicitly critiques models of individualized clinical care and notes WomanistCare’s concept of communication as going “beyond the one-hour-once-

⁷⁵ Foster Boyd, “WomanistCare,” Kindle Location 4691-4696.

⁷⁶ Foster Boyd, “WomanistCare,” Kindle Location 4732.

⁷⁷ Foster Boyd, “WomanistCare,” Kindle Location 4736.

⁷⁸ Foster Boyd, “WomanistCare,” Kindle Location 4743.

⁷⁹ Foster Boyd, “WomanistCare,” Kindle Location 4691.

a-week counseling model found in traditional psychotherapy.”⁸⁰ She names the mistrust many African American women hold towards traditional counseling models and describes WomanistCare as transcending the limitations traditional models of clinical care may incur for African American women.⁸¹

Carroll A. Watkins Ali similarly critiques clinical pastoral paradigms of pastoral care. Watkins Ali draws from womanist theology, black liberation theology, black psychology and African American literature to construct an African American pastoral theology concerned with the survival and liberation of black people. Through engaging these varied sources, Watkins Ali develops a pastoral theology that deviates from theologian Seward Hiltner’s clinical pastoral paradigm of *healing, sustaining* and *guiding* and embraces a paradigm centered around *nurturing, empowering, liberating, and reconciling*.⁸² Furthermore, Watkins Ali’s pastoral theology calls for a renewed focus on community as opposed to individuality rooted in a transformed understanding of ministry within the African American context.⁸³ This contextual pastoral theology intentionally avoids and pushes back against approaches to individualistic clinical pastoral care for African Americans and privileges communal approaches to pastoral care and counseling that reflect traditional African American values of community and corporate worship.

⁸⁰ Foster Boyd, “WomanistCare,” Kindle Location 4743.

⁸¹ Foster Boyd, “WomanistCare,” Kindle Location 4755.

⁸² Carroll A. Watkins Ali, *Survival and Liberation: Pastoral Theology in African American Context* (St. Louis, MO: Chalice Press, 1999), 9.

⁸³ Watkins Ali, *Survival and Liberation*, 8.

Womanist Pastoral Theology Between Paradigms:

Finding Our Way Back to Psychoanalysis

Phillis I. Sheppard borrows from Watkins Ali and develops an *Afrocentric womanist perspective* that marries with Heinz Kohut's self-psychology. She writes, "If we begin to appropriate the intrapsychic in womanist analysis, we will more fully represent the great complexity of black women's relationships to their varied environments."⁸⁴ Sheppard argues that womanist theology blended with both psychoanalytic theory and culture or cultural critique, works to create an effective framework for pastoral care with African American women.⁸⁵ Sheppard advocates for a contemporary womanist practical theology that is interdisciplinary, resistant to the dehumanization of black women, addresses both intrapsychic and social care needs, and intentionally creates spaces for black women to be loved, celebrated, and challenged.⁸⁶ While Sheppard refrains from situating her womanist pastoral theology in either clinical pastoral or communal contextual paradigms, her use of both psychoanalysis and social analysis in her vision for a contemporary womanist pastoral theology resonates with the contextual clinical pastoral paradigm.

Stephanie M. Crumpton further expands upon Sheppard's work and uses self-psychology and cultural countertransference as psychoanalytical tools in her womanist pastoral theology.⁸⁷ Crumpton also writes, "I pick up where Foster Boyd and Watkins Ali left off to pursue the notion of a *working image of WomanistCare* – an enfolded image of pastoral care that represents the

⁸⁴ Phillis Isabella Sheppard, *Self, Culture, and Others in Womanist Practical Theology* (New York: Palgrave Macmillan, 2011), 11.

⁸⁵ Sheppard, *Self, Culture, and Others*, 18.

⁸⁶ Sheppard, *Self, Culture, and Others*, 188.

⁸⁷ Stephanie M. Crumpton, *A Womanist Pastoral Theology Against Intimate and Cultural Violence* (New York: Palgrave Macmillan, 2014), 131.

sociohistoric experience of Black women's experience in culture and the methods that help them thrive in spite of that culture."⁸⁸ Crumpton's *working images of WomanistCare* draws from first-hand narratives of black women's lived experience, black feminist thought, self-psychology and womanist theology as well as literature indigenous to black women such as the work of Toni Morrison, Alice Walker, and Zora Neale Hurston.⁸⁹ In addition to narratives, theology, and psychoanalysis, Crumpton pays particular attention to the social sciences. She bridges statistical analysis with womanist pastoral theology to clearly articulate the contemporary social and intrapsychic needs of black women.

Crumpton's working images of WomanistCare also compels caregivers to acknowledge black women's oppression while simultaneously working to interrupt that oppression.⁹⁰ She calls for practitioners to care for black women who experience cultural violence while considering how they themselves contribute to and perpetuate cultural violence against black women. Crumpton believes that training programs such as CPE can serve as spaces for such a shift to occur through the exploration of cultural countertransference within the pastoral care encounter.⁹¹ Crumpton's womanist pastoral theology culminates with a call for healing through communal ritual and "uninstitutionalized strategies to guide Womanist pastoral support."⁹² To illustrate communal ritual, Crumpton invites readers into Toni Morrison's *Beloved*, where the character, Baby Suggs, holy works to facilitate healing and restoration for her community through worship, dance, and fellowship.⁹³ Crumpton's womanist pastoral theology and her

⁸⁸ Crumpton, *A Womanist Pastoral Theology*, 128.

⁸⁹ Crumpton, *A Womanist Pastoral Theology*, 129.

⁹⁰ Crumpton, *A Womanist Pastoral Theology*, 129.

⁹¹ Crumpton, *A Womanist Pastoral Theology*, 130.

⁹² Crumpton, *A Womanist Pastoral Theology*, 137.

⁹³ Crumpton, *A Womanist Pastoral Theology*, 131.

womanist pastoral image of Baby Suggs, holy is rooted in a communal contextual paradigm. Yet, like Sheppard, her interdisciplinary use of both psychoanalysis and social analysis resonates with the contextual clinical pastoral paradigm.

Naming the Paradigm: Contextual Clinical Pastoral Paradigm

Sheppard and Crumpton construct contemporary dynamic womanist pastoral theological frameworks for the care and caregiving of African American women. Their theologies embrace aspects of both clinical pastoral and communal contextual paradigms. For this dissertation, I go beyond situating this womanist theology as occupying a liminal space on a broad continuum of paradigmatic traditions. Rather, I name this theology as a contextual clinical pastoral paradigm. A contextual clinical pastoral paradigm describes an individualistic inter-relational approach to exploring human experience. Tools for this theological exploration include psychoanalysis and social analysis. The theological objective of the contextual clinical pastoral paradigm is to critique systems of oppression and to reimagine these systems as systems of care and flourishing.

Chaplaincy or pastoral counseling taking place within the medical or psychiatric setting generally adopts the clinical pastoral paradigm particularly through theological training including CPE. However, the clinical pastoral paradigm alone lacks contextual or social analytical capacity as its very foundation was birthed within a eugenicist clinical culture. While the communal contextual paradigm, which many womanist pastoral theologies adopt, advocates for a robust social analysis that considers cultural and social location, it values communal care over the individualistic clinical care encounter. Despite Sheppard's and Crumpton's turn toward integrating psychoanalysis into pastoral care and counseling, there remains a stark lack of praxeological method for the provision of contextualized pastoral care within the individualized

clinical setting. More specifically, as a clinical chaplain, I struggle with locating praxeological methods for individualized pastoral care within the healthcare system for African American women.

A contextual clinical pastoral paradigm therefore, goes beyond Sheppard and Crumpton's integration models and privileges the individualized clinical encounter, whether that be in a hospital room, a counselor's office, or a qualitative research interview. Within the healthcare context, ideally, every patient's circle of support surrounds them throughout their medical journey, yet it is often only the patient and myself alone in their hospital room. The individual clinical encounter within the healthcare setting is a sacred space for pastoral care. Regardless of the cultural standpoint of the patient, visitor restrictions, family obligations and other contributing factors often lead the clinical care provider to cojourn with the patient alone, with no culturally relevant small group settings or corporate worship opportunities readily or safely available. Because of the individualized nature of care within the healthcare setting, the individual clinical encounter must transform from a space of mistrust that connotes cultural incompetency and become a contextualized space of clinical pastoral care.

Within the clinical pastoral paradigm, like sacred texts, living human documents hold authority to speak on their own terms. Boisen took seriously the gestures and language of his patients, seeking to interpret, understand, and respond to their stories as if they were sacred texts.⁹⁴ He trusted and respected the "inner world of experience" as told by his patients, recognizing their own voices as authoritative in describing their psychospiritual lives. Sheppard notes, however, a general avoidance in the use of psychoanalysis in contemporary contextual pastoral theologies because "a distorted and ethnocentric view of culture and a male gender bias

⁹⁴ Gerkin, "Reclaiming the Living Human Document," 34.

have from the outset been deeply embedded in psychological theories.”⁹⁵ I imagine Boisen’s living human document was relegated to these psychological theories Sheppard describes. A contextual clinical pastoral paradigm relies on critical psychological approaches to invite renewed trust in the role of psychoanalysis in its use for exploring human experience within particular social and cultural contexts.

In addition to intrapsychic exploration of the care seeker, the contextual clinical pastoral paradigm embraces intrapsychic analysis of the pastoral care provider. Chanequa Walker-Barnes suggests pastoral care hinges upon the identity and self-awareness of the caregiver themselves.⁹⁶ The caregiver must cultivate self-awareness around their race, gender, class, and educate themselves on the lived realities of their care recipient in order to provide efficient and responsible care.

The contextual clinical pastoral paradigm integrates psychoanalysis with social analysis into its praxeological framework for exploring lived experience. Sheppard advocates for pastoral theologies “that takes seriously the psychological and the cultural.”⁹⁷ Interdisciplinary social analysis includes the use of social sciences.

Living Human Narrative

I agree with Miller-McLemore’s assertion that human beings cannot simply be read and interpreted like documents waiting for data mining. For doing so with African American women patients perpetuates the objectification and clinical mistreatment this dissertation seeks to

⁹⁵ Sheppard, *Self, Culture, and Others*, 8.

⁹⁶ Chanequa Walker-Barnes, *Too Heavy a Yoke: Black Women and the Burden of Strength* (Eugene, OR: Cascade Books, 2014), 164.

⁹⁷ Sheppard, *Self, Culture, and Others*, 8.

disrupt. However, Boisen's use of language worlds and stories appeals to the importance of storytelling in African American heritage and culture. Oral storytelling is a critical epistemology in African American communities. The wisdom carried through slavery into today's black families, demonstrate the role of oral-epistemology as a mechanism of cultural identity and survival in African American life. African American women's survival is ancestral knowledge, passed through family and spiritual systems through oral storytelling. Black women's orality emerges in the stories told by slaves that held secret codes for freedom paths. Black women's orality emerges in "granny midwives" orally passing their skills along to ensure the survival of black babies. Black women's orality emerges in recipes of remedies that soothe aches and sorrows.

African American women cannot be *read*. They are not stagnant, boring, white documents, to be filed away once interpreted. Boisen's theological heritage calls for human experience to be revered as sacred texts. A womanist theological reimagination calls them to be listened to, reverently, like stories passed down through generations. African American women must be listened to and interpreted as living human *narratives*. Edward P. Wimberly describes African American culture as an oral culture, "emphasiz[ing] emotion, celebration, poetic expression, relationships, storytelling, and story-listening."⁹⁸ African American women are engaged as living human narratives through womanist clinical pastoral paradigm that begins with their lived experiences, centers their humanity, and privileges oral culture.

This dissertation reimagines the theological study of human experience as it relates to the intersection of African American women and clinical care. There is potential in Boisen's concept

⁹⁸ Edward P. Wimberly, "The Indigenous Storyteller," in *Images of Pastoral Care: Classic Readings*, ed. Robert C. Dykstra (St. Louis: Chalice Press, 2005), 186.

to interrogate psychological and religious aspects of people's lives while acknowledging systemic and oppressive disruptions to their inner worlds. As scholarship in pastoral theology has evolved, so has the work in psychology that now centers black women and how they process their experiences. Womanist and African American psychology are critical partners of womanist pastoral theology and its endeavor to understand the inner world of African American women through a uniquely culturally located standpoint. This standpoint considers the structures of racism, classism, sexism, and ableism and seeks to acknowledge the ways systems of oppression disrupt the lived experiences of African American women.

This contextual clinical pastoral paradigm focuses on individualistic care to explore human experience and investigates inner world through critical psychoanalysis, but also takes seriously social, cultural, and political contexts. Boisen's clinical pastoral method was to listen to living human documents, interpret living human documents through psychoanalysis, and then respond to the living human document in a way that facilitates meaning making and liberation from spiritual suffering. This contextual clinical pastoral paradigm borrows the method of listening, interpreting, and responding to living human narratives. This is a womanist imagination of employing a pastoral theological paradigm within the frame of dissertation research. This dissertation research is framed as a theological exploration of human experience rooted in pastoral theological paradigmatic traditions. To demonstrate a contextual clinical pastoral paradigm, I employed critical narrative research methodology to *listen* to and interpret living human narratives. What emerges is contextual clinical pastoral *response* that critiques systems of oppression and reimagines systems so that they may contribute to the flourishing health of African American women.

Summary and Next Steps

Beginning with Boisen's psychiatric experience and construction of the living human document, pastoral theology has always embraced the theological exploration of lived experience. Overtime, as pastoral theology keeps up with postmodern and decolonial standards of inquiry, pastoral paradigms and their images have grown more contextual and communal, abandoning clinical and individualistic models of exploration. However, clinical pastoral models of theological exploration such as chaplaincy and pastoral counseling remain as consistent methods of pastoral care and counseling worthy of contextualized paradigms and images. The contextual clinical pastoral paradigm and its image of the living human narrative provides a contextualized approach to clinical pastoral care.

I collect the oral history of African American women through the qualitative interview process rather than in a traditional clinical pastoral care setting. However, facilitating black women's recalling of mistreatment must be sacred work. Therefore, I approach this qualitative research inquiry as a pastoral theological practice that benefits from a contextual clinical pastoral paradigm much like the chaplaincy space would benefit if I were to collect black women's stories at their bedside. Much like Boisen's study of living human documents, medical and healthcare research has often studied black women, using their bodies while intentionally silencing their voices. For this dissertation, I use a critical narrative research methodology grounded in epistemological claims to reimagine theological exploration of living human narratives. Chapter 3 explores those three epistemological claims and outlines a critical narrative research methodology that encompasses a narrative collection process whereby I transformed the method of interviewing into a *boundaried* storytelling space and used a poststructural narrative analysis method to interpret living human narratives.

CHAPTER 3

CRITICAL NARRATIVE RESEARCH

WITH LIVING HUMAN NARRATIVES

Our understanding of qualitative inquiry begins and too often ends from a White-centric lens. It is imperative that those committed to social and racial justice paradigms give attention to how non-White women make sense of contemporary and historical patterns. Moreover, it is equally important for us to consider the ways in which Black women seek to question, understand, and challenge, via the formal inquiry process, contemporary social injustice, like the imposition of deficit-thinking, white supremacy, and racialized gender bias in society as well as the research process itself.⁹⁹

Narrative inquiry aligns with pastoral theology's value of lived human experience and stories serving as starting points for theological reflection or discourse. While this dissertation proposes a womanist clinical pastoral theological methodology of listening to, interpreting, and responding to African American women's stories, the research methodology stems from the empirical tradition of narrative inquiry. Rooted in the humanities, narrative research, "begins with the experiences as expressed in lived and told stories of individuals."¹⁰⁰ Narrative inquiry serves as an ideal qualitative empirical methodology for womanist clinical pastoral theology as both begin by collecting stories and flow into interpretation. Narrative inquiry offers tools to both *listen* and *interpret* African American women's stories from critical frameworks situated in traditional African American oral epistemologies.

As I considered research with African American women, I wondered how to respect their boundaries, trust their stories, and center their experiences in ways that counter traditional

⁹⁹ Venus E. Evans-Winters, *Black Feminism in Qualitative Inquiry: A Mosaic for Writing Our Daughter's Body*, (New York: Routledge, 2019), 14.

¹⁰⁰ John W. Creswell, *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (Thousand Oaks, CA: Sage Publishing, 2013), Kindle Location 1540.

research methods that often neglect seeing African American women as full human beings and producers of knowledge. I, therefore, approached this critical narrative research method holding three epistemological claims. First, African American women's knowledge about their bodies and their experiences must be believed and they must be trusted as capable decision-makers about their bodies. Second, African American women's lived experience and knowledge holds privileged wisdom for critiquing and reimagining healthcare systems. Third, African American women produce knowledge through storytelling. In approaching this narrative research inquiry with these epistemological values, I departed from traditional methodologies in narrative collection and narrative analysis and constructed a critical narrative method.

Narrative research involves the collection of individual stories to explore lived experience.¹⁰¹ There are two major defining features of narrative research: narrative collection and narrative analysis. This chapter outlines the process of narrative collection and narrative analysis with living human narratives through a critical narrative research method. I first explore the three epistemological claims and their theoretical foundations. Next, I describe the narrative collection process whereby I transformed the method of interviewing into a *boundaried* storytelling space. Finally, I introduce the poststructural narrative analysis method I used to interpret living human narratives - *thinking with theory*.

Epistemological Starting Points

Starting Point: Reproductive Justice Theory

Epistemological Claim: African American women's knowledge about their bodies and their experiences must be believed and they must be trusted as capable decision-makers about their bodies.

¹⁰¹ Creswell, *Qualitative Inquiry and Research Design*, Kindle Location 1559.

Birthered by women of color in the late 1990s, the reproductive justice movement sought to address three primary concerns: the right to not have children, the right to have children, and the right to safely and healthily parent children.¹⁰² The reproductive justice movement pays particular attention to the lived experiences of women of color whose “reproductive capacity” has historically been limited as a means for white power (population control) or used as a means for white wealth (slavery).¹⁰³ A reproductive justice framework keeps historical, political and contextual oppression at the forefront of discussion, and challenges existing paradigms that continue to perpetuate such oppression.¹⁰⁴ It analyzes metasystems such as law, economics, and academia and works to critique white supremacist policies, legislation, and normative practices that determine the value of black women’s lives and their capacities to make decisions. RJT focuses specifically on a woman’s ability to self-determine her own decisions around her sexuality and reproductive health.¹⁰⁵ Furthermore, it examines the social constructs of race, sexuality, gender, and class and highlights how these intersections, along with socially imposed boundaries, impact reproductive and healthcare decision-making.¹⁰⁶

Rebecca Todd Peters identifies not trusting women as the core barrier to recognizing women as moral agents capable of moral decision-making. For Todd Peters, this inability to trust women’s decisions about their own lives and bodies stems from theological imagination.¹⁰⁷ Todd Peters avers,

¹⁰² Loretta J. Ross and Loretta J. Ross et al., “Introduction,” in *Radical Reproductive Justice: Foundations, Theory, Practice, Critique* (New York, NY: Feminist Press, 2017), Kindle Location 144-Kindle Location 193

¹⁰³ Ross and Solinger, *Reproductive Justice*, 11.

¹⁰⁴ Ross and Solinger, *Reproductive Justice*, 11.

¹⁰⁵ Ross, “Conceptualizing Reproductive Justice Theory,” Kindle location 3245.

¹⁰⁶ Ross, “Conceptualizing Reproductive Justice Theory,” Kindle location 3422,

¹⁰⁷ Rebecca Todd Peters, *Trust Women: A Progressive Christian Argument for Reproductive Justice* (Boston: Beacon Press, 2018), 6.

The problem that we face in this country is our failure to trust women to act as rational, capable, responsible moral agents. At its root, this inability to trust women stems from the ongoing legacy of misogyny and patriarchy that continues to shape a cultural desire to control the lives and bodies of women.¹⁰⁸

For Todd Peters, reproductive justice addresses this legacy of misogyny and patriarchy. The reproductive justice framework departs from issues of reproduction to include all issues of women's health and healthcare, including reproductive health. For this narrative research inquiry, I trust that Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena each know their bodies and their stories better than anyone else. Through a reproductive justice framework, I analyze their stories, not through a judgmental gaze, but through believing their experience, trusting their decisions, and respecting how they pursue and manage their healthcare.

Starting Point: Black Feminist Standpoint Theory

Epistemological Claim: African American women's lived experience and knowledge holds privileged wisdom for critiquing and reimagining healthcare systems.

Leith Mullings purports that in research, "African-American women continue to be defined in ways the deny their humanity."¹⁰⁹ Research with African American women has often been conducted under a white scientific gaze. Rather than continue with the legacy of rote research in the scientific method, I approached collecting the oral history of African American women as sacred, indigenous work. I approach this work, wanting African American women to define and speak for themselves.¹¹⁰ To do so I challenge traditional epistemologies that establish hierarchal separation between "the knower and the known."¹¹¹ I am grounded in a black feminist

¹⁰⁸ Todd Peters, *Trust Women*, 6.

¹⁰⁹ Leith Mullings, "African-American Women Making Themselves: Notes on the Role of Black Feminist Research," *Souls* 2, no. 4 (Fall 2000): 18.

¹¹⁰ Brianna Toole, "From Standpoint Epistemology to Epistemic Oppression," *Hypatia: A Journal of Feminist Philosophy* 34, no. 4 (2019): 598-618.

¹¹¹ Mullings, "African-American Women Making Themselves," 20.

epistemology that resists privileging the knowledge of myself as the researcher and in turn privileges the knowledge production of African American women in particular.

Black feminist thought is a critical social theory addressing injustices experienced by black women based on the tripartite oppressions of race, gender, and class. Black feminist epistemology, therefore, challenges traditional models of knowledge production, allowing even the most marginalized in society – namely, poor black women – to be both producers and possessors of knowledge.¹¹² Patricia Hill Collins describes black feminist epistemology as black women’s wisdom based on collective historical experiences.¹¹³ This shared and passed on knowledge, for Hill Collins, becomes “the collective wisdom of a Black women’s standpoint.”¹¹⁴ Black feminist standpoint theory in particular calls for black women-centered experiences to be the starting-point for effective and transformative research. Evans-Winters contends that African American women’s oppressed status in society provides them with a unique and privileged standpoint to critique, analyze, and interpret sexist and racial oppression.¹¹⁵ If wisdom for critiquing and reimagining systems is in the lived experience and knowledge of those whom the system most adversely impacts, African American women have the privileged standpoint to critique the healthcare system and reimagine it as a system of care and flourishing.¹¹⁶

¹¹² Mullings, “African-American Women Making Themselves,” 19.

¹¹³ Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*, (New York: Routledge, 2000), 256.

¹¹⁴ Patricia Hill Collins, *Black Feminist Thought*, 256.

¹¹⁵ Evans-Winters, *Black Feminism in Qualitative Inquiry*, 17.

¹¹⁶ Brianna Toole, “From Standpoint Epistemology to Epistemic Oppression,” *Hypatia: A Journal of Feminist Philosophy* 34, no. 4 (2019): 598-618.

Starting Point: Oral Communication

Epistemological Claim: African American women produce knowledge through storytelling.

Loretta J. Ross and Rickie Solinger describe storytelling as “an act of subversion and resistance... [Stories] help us understand how our human rights – and the human rights of others – are protected or violated.”¹¹⁷ Stories are used to bring about justice in spaces where black women’s humanity is often denied. Imperative to black feminist epistemology is the capturing of both black women’s oppression *and* resistance.¹¹⁸ Gathering stories through interviews served as an effective method to capture both the mistreatment and the spaces of meaning making, resilience, self-advocacy, and community action. Evans-Winters avers, “Speech in the African and African American tradition, in written or oral form, is regarded as a creative and divine act.”¹¹⁹ Storytelling, oral histories, and other oral-epistemologies appeal to black women’s cultural situatedness while the dialogical nature of storytelling allows for mutuality within the research process.^{120,121}

While I used interview questions to guide the interview process, I privileged a dialogic conversational approach. Hill Collins notes the importance of the “call-and-response discourse mode” central to African American communication. She argues that this consistent practice in black communication signals the importance of dialogue in African American women’s

¹¹⁷ Loretta Ross et al., eds., *Radical Reproductive Justice* (New York: Feminist Press, 2017), Kindle Location 59.

¹¹⁸ Hill Collins, *Black Feminist Thought*, 18.

¹¹⁹ Evans-Winters, *Black Feminism in Qualitative Inquiry*, 22.

¹²⁰ Evans-Winters, *Black Feminism in Qualitative Inquiry*, 22.

¹²¹ National Centre for Collaboration in Indigenous Education, “Dr. Jo-ann Archibald on Indigenous Storytelling,” YouTube Video, 41:54, October 3, 2019, https://www.youtube.com/watch?v=5rSHifM35i4&feature=youtu.be&ab_channel=NationalCentreforCollaborationinIndigenousEducation.

production and assessment knowledge.¹²² In LaRhonda S. Manigault-Bryant's ethnographic study of women in the Gullah/Geechee community, she speaks to the importance of griots in African American culture as "being the keepers of culture through their storytelling abilities, sharp memory, and profound ability to shape the structure of history."¹²³ She describes the women she studies as "culture keepers," similar to griots, who use story to preserve their language, their traditions, and spiritual practices for generations.¹²⁴ With dialogue and story as central to the cultural preservation and knowledge production of African American women, privileging oral communication in collecting their lived experiences in turn privileges a culturally indigenous practice of research.

Narrative Collection

Narratives can be gathered through many varied forms of data including interviews, documents, and pictures.¹²⁵ Because I approached this narrative research claiming that communities rooted in oral cultures produce knowledge through storytelling, I privileged the interview as the critical narrative research collection method. As Marsha Foster Boyd describes in her work on WomanistCare, African American women must be "listened into life."¹²⁶ The qualitative interview transformed into a contextualized space for theological exploration where the African American women who participated in my research were listened into life. It was both a space for sacred storytelling and a space to collect oral data. It reminded me of the hospital

¹²² Hill Collins, *Black Feminist Thought*, 261.

¹²³ LeRhonda S. Manigault-Bryant, *Talking to the Dead: Religion, Music, and Lived Memory Among Gullah/Geechee Women* (Durham, NC: Duke University Press, 2014), 65.

¹²⁴ Manigault-Bryant, *Talking to the Dead*, 65.

¹²⁵ Creswell, *Qualitative Inquiry and Research Design*, Kindle Location 1571.

¹²⁶ Foster Boyd, "WomanistCare," Kindle Location 4758.

bedside. As I provide clinical pastoral care to patients I listen to their stories, trust their stories, center the stories. Much like providing pastoral care in the clinical encounter, collecting the oral history of black women recalling their experiences of mistreatment and telling how they made it through, is sacred work.

Recruitment and Informed Consent

Following approval through Claremont School of Theology's Institutional Review Board, I personally recruited all but one woman to interview and each woman was recruited either in person or through text message. Eight to ten women were expected to be interviewed for this dissertation, and I found eight women who not only had stories of mistreatment within the American healthcare system, but were also willing to share. Three additional women were recruited in the beginning of the research process and agreed to be interviewed. When it came time to schedule the interviews, two women chose not to respond and the third ultimately declined to be interviewed three months into dissertation research. I quickly reached out to Tamika, recruited her for the study, and within a week conducted my eighth interview. It was one of the shortest interviews and one of the least chronologically coherent stories. At the beginning of our interview, I chose to inform Tamika that hers was my last. I now wonder if sharing this information with her contributed to our conversation's choppiness and brevity.

Recruitment for interviews began in December of 2019, following approval of my dissertation proposal and the Institutional Review Board's (IRB) approval I reached out to friends, family, sorority members, and classmates, informing them of my dissertation topic and asking if they have a story to tell. Along with this message, I created a digital flier that allowed for my research and contact information to be easily disseminated. Placing the information in a single, visually attractive, and accessible image appealed to the adult, socially conscious, and

Instagram savvy African American women demographic I sought to recruit (see Appendix A). Once Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena expressed interest in participating, I provided them with more information around the topic through conversation and the informed consent form (see Appendix B). The women had the opportunity to review the informed consent form and ask questions prior to our interview. No participant had any significant questions or concerns before, during, or following the interview process.

Research Partners

I have a relationship, outside of this research project, with each woman interviewed. Our relationships vary significantly – some are familial and others more collegial. Some I have known all of my life and others for a few years. With all the women, however, I have hugged, laughed, worshipped, and shared food. With most I have sang, danced, and gossiped. With some, I have cried, fought, and screamed. I held their children and washed their feet. I braided their hair and borrowed their clothes and slept on their couches. We pass around books and recipes and prayers. Some women know one another and of one another's participation in the interview study. However, we each kept our time together, as storyteller and story-listener, sacred and confidential in that moment. My knowledge of and relationship with the eight women enriched our interview process and my data analysis. I took advantage of my knowledge of the interviewee's symbolism and language. As six of the interviews occurred through video, I took advantage of my knowledge of the women's body language, their nonverbal communication, and their audible sighs. With ease I identified when anger began to quiver their voices, when tears began to fill their throats, and I heard their eye rolls from miles and miles away. My knowledge of the women's family systems, community involvements, social achievements, and even church affiliations made space for creative, confident, and well-rounded interpretations of their stories.

At times, the women took advantage of our relationships as well – particularly my kinfolk. My family’s interviews were the shortest. I heard their stories before, knew their stories, *cojourne*¹²⁷ with them through the pain of their illnesses and hospitalizations. They took for granted my knowledge of their suffering and relied on what was missing in words to be filled through the wisdom of our relationships. As I began narrative analysis, at times I regretted the brevity of our interviews and imagined new approaches or follow-up questions or another, fuller, interview. However, as the stories began to take shape on the pages of the dissertation, I found that in fact, I had what I needed. Even in short conversations, rich images, themes, and curiosities erupt. Stories begin to weave with others, braiding together to form tapestries of meaning. No story was singular, but rather a part of a collective canon of narratives intended to tell the story of treatment of African American women in the healthcare system.

All eight research partners identify as adult African American women and reside in Southern California during their encounter of mistreatment, living in either the Los Angeles, San Diego, or Inland areas. Southern California is quite racially and religiously diverse, and for me, epitomizes diversity and acceptance of differences in language, culture, and country of origin. However, California is also drenched in its own cultural forms of racism and racial discrimination. The Los Angeles Police Department in Los Angeles County and the Santa Ana Police Department in Orange County are two of the deadliest and racist police departments in the country. African American, Korean, and Latinx communities experience generational intra-racial tension, and many racial-ethnic communities speak about the L.A. riots of 1992 as if it were yesterday. Interviewing women with experiences of mistreatment based on their intersectional identities as African American women complicates idyllic projections of Southern California and

¹²⁷ Foster Boyd, “WomanistCare,” Kindle Location 4728.

calls to question the role of these unique racialized Californian experiences on the collective psyche of Californian black women coping with racial bias. Geographic considerations also leave open to imagination the contemporary treatment of African American women in geographic areas with more overt anti-black racism such as Southern states with historical ties to slavery.

Unintentionally, every woman other than Alicia falls under the age group of “millennials” ranging in 25-36 years old. While each woman holds at least a bachelor degree, Alicia, Stacey, Tamika, and Jemel have master degrees as well. There is great significance in interviewing young, educated, professional, and socially conscious African American women about the American healthcare system. Their stories of mistreatment in light of their social status highlight the universality of black women’s suffering. These women have education, connections, and influence, *and* their stories are surprising, challenging, and upsetting. Societal buffers such as education, employment status, zip code, even health insurance, are mythically intended to mitigate health disparity and even racialized trauma. An interview study with eight well-educated, professional, and socially-involved women demonstrates that being both black and woman outranks almost any societal buffer.

The Interview Process

Eight interviews were conducted over the course of January through April 2020. The first two interviews were in person, however, due to the pandemic, the remaining six interviews occurred through video using FaceTime. The COVID-19 pandemic disrupted more than my interview process – it upended any hope African Americans had in the American healthcare system and confirmed our federal government as incompetent in developing any comprehensive national healthcare response. Black suffering seemed inescapable and intrinsically linked to

health and healthcare more than ever before. Inequalities in both health and healthcare in the United States were a trending topic and everywhere I turned virtual conferences and symposiums, roundtables and thinktanks, news segments and press conferences all centered black and brown communities as victims of this novel deadly disease. Collective black suffering was magnified by on-going and often deficit-laden accounts of black victimization.

The interviews ranged from twenty minutes to an hour. I took brief notes throughout the interview – primarily to note curiosities I hoped to return to further in our conversations. I recorded each interview keeping the audio recorder visible and central throughout the conversation. I refrained from video recording the interviewee for her confidentiality. Each video interview was conducted over secured internet and held in a quiet and confidential location. The participants also participated from quiet and confidential locations, however, many of their small children made audible or physical appearances. Most interviews were conducted over the weekend or while the participant was working from home. She was often multi-tasking, caring for family while sitting to be interviewed. The pandemic disrupted so much of our daily schedules that routines, for a time, were obsolete. For a few women, such as Opal, it was difficult to find mutually agreed upon times for our interview. She often cited childcare as the cause for rescheduling. Nonetheless, the eight women and I found time in the midst of chaotic pandemic to sit down, listen, and dream.

Collective Boundary Setting

Most of the interviews were conducted during a moment in American history when the intersections of race, health, and healthcare were up and down our newsfeeds. African Americans were constantly being told that they were dying, and being told that because of their preexisting condition of being black in America, there was nothing they could do about it. There

was a sense of simultaneous and collective fear, anxiety, and grief. Throughout the research process I wondered if these conversations at the intersection of race, health, and healthcare would be too triggering, even for me. As I proposed my dissertation project prior to the pandemic, I proposed collective boundary setting – a set of questions intended to set boundaries around the interview to mitigate emotional harm. As we collectively turned toward coping through a pandemic, collective boundary setting reiterated and strengthened a concern for my research partners' well-being and a respect for their emotional limitations in talking about health and healthcare.

Collective boundary setting involves both the interviewer and interviewee co-creating a safe, confidential, and *boundaried* space for the interview process. Collective boundary setting originally sought to accomplish two tasks. First, departing from traditional research frameworks where the researcher and the researched embody significant power differentials, collective boundary setting empowers the interviewee to take part in the flow of the interview process. Collective boundary setting ensures that the interview adheres to the interviewee's criteria of a safe space as she is able to set the boundaries of what she is willing and unwilling to discuss about sensitive issues such as her health. Second, with the assumption that enflashed trauma often accompanies clinical mistreatment, setting such boundaries at the beginning of the interview process seeks to prevent re-traumatization. Collective boundary setting between the interviewer and interviewee intends for the interviewee to feel empowered, liberated, and safe to share that which she wants in the manner in which she wants. In a society where, black women's boundaries are often ignored and crossed, particularly within the healthcare system, collective boundary setting for interviewing African American women about their health dismantles sociohistorical precedents of disrespecting boundaries and places the notion of respecting black

women at the forefront of the interview process. As the pandemic raged on, a third task emerged for collective boundary setting with interviewing African American women. It claimed respect for and appreciation of her emotional limitations in the midst of communal suffering and lament. Because black suffering seemed inescapable on social media, television, and news articles, collective boundary setting invited the interviewee to decide what information she wanted to consume and discuss, and what she did not. Collective boundary setting includes six guiding questions:

1. What do you (the interviewee) hope to accomplish during the interview?
2. What questions or topics regarding your (the interviewee) health are off limits?
3. What questions or topics regarding your (the interviewee) healthcare are off limits?
4. What other general topics should we avoid during the interview?
5. What can be a “safe phrase” that signals crossed boundaries?
6. What can I (the interviewer) do to ensure this is a comfortable and safe space for you (the interviewee) to share your story?

Interviewing for Stories of Mistreatment

Following our cocreation of boundaries for our interview process, the interviewee was invited to share her story of mistreatment. Five guiding questions were identified to frame each woman’s story. Of course, due to the conversational aspect of our interviews, stories of mistreatment were told in different ways at different points in each conversation. Some stories took under ten minutes to tell, some took an hour. Some stories were seemingly told in one single breath. Others jumped from plot to plot, hoping I would keep up. The women were aware of the topic, purpose, and nature of our interview beginning with the recruitment process, therefore almost every woman prepared her story ahead of our conversation. Five guiding

questions were often asked in consecutive order, however, at times, questions were asked organically, as the conversation flowed:

1. Can you tell me the story of your health (i.e. diagnoses, prognoses, medical history)?
2. How would you define mistreatment as it refers to the American healthcare system?
3. How did you experience mistreatment in the American healthcare system?
4. How do you understand your story of mistreatment in light of your identity, namely your race, class, and gender?
5. Can you describe how this mistreatment impacted your health and your life?

Interviewing for Stories of Meaning Making

The transition to meaning making emerged from Boisen's work around the pastoral task interpreting of living human documents and facilitating meaning making. I could not prescribe meaning to the participant's experiences with mistreatment – they needed to do so themselves. Womanist theology informed wondering how each woman would want to be treated should she have future experiences similar to the one shared in her story. In this question was hope for reclamation of one's experience and time, providing the interviewee with opportunity to declare how she deserves to be treated. African American psychology and black spirituality informed wondering how God intervened in the lives of the participants following their encounter. Womanist theology and qualitative methodology informed the final question, that mirrors the first asked during collective boundary setting. On one hand, the question opened a portal for imagining how one's words and actions could shift an entire system. This is womanist work, as the action of telling one's story has the liberating and prophetic power to transform families and communities. On the other hand, this question served as a sort of exit survey. Because this

question mirrored the first question asked, it revealed changes in perspective and any lingering unfinished business. It was in this question that each woman was most imaginative – sharing her hopes and dreams for community initiatives and for legacies impacting generations to come. Three questions were used to transition from their story of mistreatment to meaning making using a womanist psychospirituality:

1. How would you want to be treated as a patient in the American healthcare system?
2. What do you think God would say or express regarding your story of mistreatment?
3. How do you hope telling your story of mistreatment transforms and improves the way African American women are treated within the American healthcare system?

Data Collection and Storage

The interviews were recorded through audio-recording phone application. Following the interview, each audio recording was transferred to my personal laptop and stored within an encrypted file. Each participant was assigned her own file filled with their audio recording, transcript, narrated story, and memo notes.

Limitations

In proposing this dissertation and its methodology, I proposed a group interview at a central location such as a local Orange County church. However, during the recruitment process, Alicia expressed disinterest in a group interview and I began to rethink my approach. Once the stay-at-home-order was in place, I chose to forgo a group interview altogether. I do think a collective space for healing and lament among the black women I interviewed would have been tea for the soul in the dreary pandemic. I imagine a Zoom meeting with all nine of us on video would spark laughter, prayer, reflection, affirmation, and tears. Yet, like the women interviewed, I, too, was impacted by the deleterious symptoms of the pandemic such as anxiety, fatigue,

panic, and burnout. As an essential clinical chaplain, I *cojourne*d with many patients and families through the COVID-19 pandemic facilitating healing, lament, and hope. Self-awareness and Spirit's wisdom affirmed that I could not cojourn with many more. My option to not facilitate a virtual group interview, however, did not impact the richness that came from the women's individual stories that were thick with strands to braid and weave to form collective images and themes. I would, however, be remiss to not assume that the pandemic *and* its' Zoom fatigue, healthcare news burnout, societal chaos, and mass death was a significant but uncontrollable conscious and subconscious limitation throughout the interview, analysis, and writing process.

All eight women represent similar social locations. I recruited these women from the spaces of privilege from which I have access such as higher-education, sorority membership, and a supportive family system. The study would be enhanced by including African American women from wider socioeconomic and educational strata to further explore the universality of black women's experiences of mistreatment. Furthermore, as previously mentioned, my interpersonal relationship with each interviewee proved both beneficial and limiting. Limitations include brevity and vagueness in responses as my research partners took for granted my knowledge of their stories and language.

Summary of Narrative Collection

Interviewing served as the most sufficient method for collecting living human narratives, but also posed challenges. Scheduling difficulties, brief interviews, and general pandemic woes posed as limitations. But, when we found space to sit, to story-tell and to story-listen, I interviewed Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena to theologically explore their experiences of mistreatment and how they came to make meaning out of that mistreatment. Through remaining rooted in my epistemological values, I intentionally co-created

and maintained boundaries with the women as to not contribute to the perpetuation of mistreatment in clinical [pastoral] research. What emerged from this *boundaried* space were stories filled with rich gateways into the inner-worlds of African American women.

Narrative Analysis

Coding

Following the interview process came narrative analysis. I began interpreting living human narratives through coding – searching for common themes, or meaning units, in interview transcripts. For traditional narrative research analysis, coding is a mechanical categorization process for interpretation.¹²⁸ Svend Brinkmann and Steiner Kvale describes this process as “the interpreter go[ing] beyond what is directly said to work out structures and relations of meaning not immediately apparent in a text.”¹²⁹ As I began to interpret the interview data, codes were extracted from each woman’s story. I determined *a priori* codes based on the women’s definitions of mistreatment.¹³⁰ I summarized these codes into common terms from my own lived experience and condensed layered and complex meaning into one or two-word codes or themes. Codes were then interrogated in the attempt to read beyond “what is directly said to work out structures and relations of meanings not immediately apparent in a text.”¹³¹

I coded both the women’s narratives of mistreatment as well as their narratives of meaning making. Within narratives of mistreatment, I identified the following codes: suspicion, dismissiveness, apathy, bias performance, disrespect, and stereotyping. Within the first draft of

¹²⁸ Svend Brinkmann and Steiner Kvale, *InterViews: Learning the Craft of Qualitative Research Interviewing* (Los Angeles: Sage Publications, Inc., 2015), 231.

¹²⁹ Brinkmann and Kvale, *InterViews*, 235.

¹³⁰ Brinkmann and Kvale, *InterViews*, 235.

¹³¹ Brinkmann and Kvale, *InterViews*, 235.

this dissertation, I named these codes as common themes in mistreatment experienced by the women I interviewed. These codes assisted in exploring the research question, *what occurs within the clinical care encounter leaving African American women with a story of mistreatment?* In exploring how these themes emerged in each woman's narrative, I hoped to further unpack these feelings of mistreatment even further. I turned to the theoretical concept of transference, introduced by Sigmund Freud and contextualized by Pamela Cooper-White and Stephanie Crumpton and constructed the theoretical concept of cultural transference-countertransference comprised of a confluence of metatheory in cultural transference and cultural countertransference.

Within narratives of meaning making, I identified the following codes: trust, respect, hospitality, awareness of assumptions, living out beliefs, divine intervention, self-advocacy, relationship building, and critical thinking. These themes addressed the research question, *how do black women make meaning out of their mistreatment in order to maintain their resilience and continued reliance on the healthcare system?* I further categorized these codes as the women's sense of connectedness to self, others, and the divine, the women's sense of an intervening God, and the women's expectations of providers. I turned to major concepts in African American/Black and womanist psychologies that examine the role of spirituality in African American women's coping with racism and sexism in healthcare settings as well as the role of spirituality in shaping value systems that dictate expectations of clinicians in society. Finally, I turned to Delores William's womanist theology and her concept of *wilderness-experiences* as told through the Hagar story of the Hebrew Bible to explore the women's faith in divine intervention in the midst of their healthcare crises.

In the first and second drafts of this dissertation, I categorized the codes found in narratives of meaning making as either womanist values for healthcare systems or for African American women patients. Values my research partners held for healthcare systems include trust, hospitality, asking questions/suspending assumptions, and respect. Values my research partners held for African American women patients include self-advocacy, critical thinking, community engagement, and relationships with care providers. I described these values as womanist because they were born from the lived experiences of African American women and argued that by adopting these values, the healthcare system would be better suited to care for all people. In addition, I argued that by adopting womanist values for patients, African American women may find methods to interrupt mistreatment within the clinical encounter. In my final draft, I revised the idea describing a broad womanist value system and returned to the idea of call-and-response.

In addition to the coding described above, I identified terms or phrases within each woman's narrative as a *call* within a call-and-response discourse. For example, Alicia called for education in her narrative, Opal called for critical thinking, and Patrice called for black women to trust their bodies. Despite naming the calls, in my first and second drafts, I refrained from offering a response, an important task in call-and-response discourse mode. Rather than womanist values, the codes now outline my research partners' collective calls *for* response. The collective calls integrate each woman's individual call originally identified within her narrative. I provide the collective calls as well as my response in Chapter 8.

Narrating Narratives

Following the coding process, I left the women's stories alone in order for them to speak for themselves. Rather than chop up the women's stories to fit into constructed thematic categories of lived experience, I chose to keep individual interviews as singular stories. The raw

data of interviews was transformed into chronological individual narratives. As John Creswell suggests, the participants rarely told their stories in a chronological order. Organizing stories into a beginning, middle, and end therefore becomes one of the primary features of this narrative research.¹³² I organized each interview into a chronological story with centralized plots and characters.¹³³ As I narrated each interviewee's story I entered her world and attempted to imagine myself in the back of the ambulance, at the community clinic, or in a hospital bed. I hoped to do the women justice in my narration of their stories, honoring the cadence and rhythm in their speech, their metaphors and symbolism, and their California-girl-isms.

I then sent each interviewee her narrated story and invited her to consider the following three questions: does this accurately depict what you hoped to share; are there pieces of the story missing; and, are there spaces of misinterpretation? Creswell suggests that actively involving participants in the research process encourages both the researcher and the participant to learn and reflect throughout the research process.¹³⁴ He notes, "In this process, the parties negotiate the meaning of the stories, adding a validation check to the analysis."¹³⁵ This validation process allowed me to adjust their stories in accordance with their responses. In essence, in editing and reducing raw interview data into a coherent, chronological narrative, I hoped to capture the fullness of each woman's knowledge of her body, her experience, and her critique of the healthcare system.

¹³² Creswell, *Qualitative Inquiry and Research Design*, Kindle Location 1634.

¹³³ Creswell, *Qualitative Inquiry and Research Design*, Kindle Location 1571.

¹³⁴ Creswell, *Qualitative Inquiry and Research Design*, Kindle Location 1646.

¹³⁵ Creswell, *Qualitative Inquiry and Research Design*, Kindle Location 1646.

For my second and final draft I employed an additional interpretive method that, as Alecia Y. Jackson and Lisa A. Mazzei describe, “gets us out of the representational trap of trying to figure out what the participants in our study ‘mean,’ and helps us to avoid being seduced by the desire to create a coherent and interesting narrative that is bound by themes and patterns.”¹³⁶ Jackson and Mazzei describe this process as *thinking with theory*. Jackson and Mazzei argue, “qualitative data interpretation and analysis does not happen via mechanistic coding, reducing data to themes, and writing up transparent narratives that do little to critique the complexities of social life.”¹³⁷ Instead, they advocate for “dense and multi-layered treatment of data.”¹³⁸ I integrate thinking with theory with thematic coding and in turn deeply engage the narratives with the constructed hermeneutics of culture and psychospirituality.

I interpret each woman’s individual narrative and their codes through an itinerant process of plugging the narrative into theory and the theory into the narrative.¹³⁹ I began this process of narrative analysis before I knew the term thinking with theory. I constructed what I term theoretical hermeneutics, or interpretive tools, that when applied to African American women’s lived experience expand my thinking about mistreatment and black women’s relationship to healthcare. Likewise, integrating living human narratives into constructed theoretical frames puts the theories to work¹⁴⁰ and contributes to further construction of the theories themselves. The

¹³⁶ Jackson and Mazzei, *Thinking with Theory*, Kindle Location 122.

¹³⁷ Jackson and Mazzei, *Thinking with Theory*, Kindle Location 104.

¹³⁸ Jackson and Mazzei, *Thinking with Theory*, Kindle Location 104.

¹³⁹ Jackson and Mazzei, *Thinking with Theory*, Kindle Location 97.

¹⁴⁰ Alecia Y. Jackson and Lisa A. Mazzei, “Plugging One Text Into Another: Thinking With Theory in Qualitative Research,” *Qualitative Inquiry* 19, no. 4 (2013): 264.

narratives both strengthened and actively built the hermeneutics, while the hermeneutic played with codes, language, ideas, and knowledge produced in the narratives.

After being introduced to thinking with theory, I organized my narrative analysis into meeting the three moves Jackson and Mazzei categorize as central to their methodological process of plugging-in.¹⁴¹

1. putting philosophical concepts to work via disrupting the theory/practice binary by decentering each and instead showing how they *constitute or make one another*;
2. being deliberate and transparent in what analytical questions are made possible by a specific theoretical concept (e.g., deconstruction or performativity) and how the questions that are used to think with *emerged in the middle* of “plugging in;” and
3. working the same “data chunks” repeatedly to “deform [them], to make [them] groan and protest” (Foucault, 1980, p. 22-23) with an overabundance of meaning, which in turn not only creates new knowledge but also shows the *suppleness of each when plugged in*.¹⁴²

Below I describe how I followed these three maneuvers in my pursuit of narrative analysis with living human narratives.

Disrupting the Theory/Practice Binary

I developed the theoretical framework following the interview process in my search for interpretive tools that could meet the complexity of black women’s lived experience. This complexity, as told through their narratives, calls for new theoretical tools for intrapsychic exploration that resist barriers between the psychological, the theological, and the cultural. The narratives not only established the need for more robust theoretical concepts, but they determined how to construct the concepts as well. It was because of their stories that I searched for language to name behaviors and feelings about culture, race, and gender. I searched for language and theories to name resilience and spirituality while honoring psychological duress. In constructing

¹⁴¹ Jackson and Mazzei, “Plugging One Text Into Another,” 264.

¹⁴² Jackson and Mazzei, “Plugging One Text Into Another,” 264.

these theoretical frameworks and “putting philosophical concepts to work” in the interpretation of the narratives, the narratives opened to provide deeper understanding of black women’s cultural and psychospiritual lives.¹⁴³ In their own process of thinking with theory, Jackson and Mazzei note, “The data were not centered or stabilized, but used as brief stopping points and continually transformed, and exceeded, as we used theory to turn the data into something different, and we used data to push theory to its limit.”¹⁴⁴ In exploring living human narratives, this became a reciprocal and integrative process where the interpretive tools are subject to consistent reshaping, reforming, and redefinition and the women’s stories are subject to consistent and ongoing reinterpretation.

Theologically reimagining each qualitative interview as a living human narrative symbolizes my disruption of the theory/practice binary. I entered into this critical narrative research grounded in womanist clinical pastoral theory with its metaphor and praxeological method. I integrated reproductive justice theory, black feminist standpoint theory, and the indigenous practice of African American storytelling into the research design, narrative collection, and analysis process. I no longer looked at the interview process as only a qualitative research tool, but as a storytelling process rooted in ancestral traditions. The research space also transformed into a *boundaried* space through collective boundary setting. This transformation is rooted in putting reproductive justice theory to work and trusting, respecting, and protecting black women’s bodies and their knowledge about their bodies. As I enter into narrative analysis, I ritualized and communalized the narration of each story through honoring voice and sharing

¹⁴³ Jackson and Mazzei, “Plugging One Text Into Another,” 264.

¹⁴⁴ Jackson and Mazzei, *Thinking with Theory*, 6.

transcripts with participants. My womanist clinical pastoral theological grounding in the metaphor of the living human narrative prioritizes the disruption of the theory/practice binary.

Asking Analytical Questions

Whereas Jackson and Mazzei suggest developing analytical questions informed by the major concepts intended to be plugged into the data,¹⁴⁵ I constructed the hermeneutics of culture and psychospirituality to assist in answering the research questions I originally designed. While I constructed these theoretical hermeneutics to explore already-developed research questions, the narrative analysis process of plugging in produced more analytical questions along the way. These budding questions opened and expanded the narrative analysis process. Not only did the hermeneutics expand and unpack the narratives, but they also highlighted the codes in new and surprising ways. Codes connoting apathy, dismissiveness, and distrust undergirded frameworks producing controlling images of African American women patients. The hermeneutic of psychospirituality played with codes of divine intervention and self-advocacy and produced new questions to address cultural coping strategies and the role of spirituality in healthcare crises.

Making Narratives Groan and Protest

I worked with the narrated stories for many months. I explored the stories through each hermeneutic of culture and psychospirituality and through each “working” of each story, I learned something new about the participant, her experience, my perception of mistreatment, and my understanding of black women making meaning out of their experiences. As Hill Collins suggests, dialogue between African American women produces knowledge, so I continued to return to the stories with the theories, to continuously find what more knowledge could be revealed through on-going interpretation. I appreciate Jackson and Mazzei’s adopted image of

¹⁴⁵ Jackson and Mazzei, *Thinking with Theory*, 7.

data groaning and protesting, as the knowledge that continued to flow from the women's narratives groaned with pain from mistreatment while protesting with bold power against their experiences.

The *suppleness* of each narrative was revealed through the many ways each one produced new ideas, new language, and new theory over time. As the narratives and theories were plugged in to one another, the theoretical concepts morphed and grew to embrace complexity and the living human narratives spoke and cried out. thinking with theory allows the data to come alive. It allows the data to speak for itself, to grow, to challenge, and to produce new ways of thinking and knowing. Thinking with theory as a narrative analysis methodology honored the complex, ever-evolving, and the human nature of living human narratives as they writhe in pain from mistreatment and yell out with power for change.

Summary and Next Steps

The eight living human narratives collected by Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena through individual interviews produced meaningful knowledge that arrives at a shared and collective understanding of mistreatment in healthcare systems and reveals values that support treating African American women fairly and justly to facilitate their healing. Their narratives were also counterstories to research that neglects to report both oppressive experiences and moments of resistance and resilience. Throughout narrative collection and analysis, I valued each woman's story as sacred and honored boundaries, feelings, language, and culture.¹⁴⁶ Eight African American women experienced what they defined as mistreatment in the American healthcare system and were invited to share their stories through

¹⁴⁶ Evans-Winters, *Black Feminism in Qualitative Inquiry*, 23.

an interview. Despite the majority of interviews being held through video due to the pandemic, narratives produced knowledge that when interpreted by hermeneutics of culture and psychospirituality expand this knowledge and produced more knowledge. This itinerant process of plugging theory and narratives into one another opened up new ideas to understanding mistreatment and the American healthcare system's relationship with African American women. The following chapter outlines the beginnings of the critical narrative research process, listening to living human narratives of mistreatment.

CHAPTER 4

LISTENING TO LIVING HUMAN NARRATIVES:
NARRATIVES OF MISTREATMENT

Narratives of Mistreatment

Chronic illness, maternal and reproductive health, and mental illness are just but a few ways African American women enter into the American healthcare system. Consequently, their reliance on, or, participation in, the healthcare system potentiates challenging encounters with racism, sexism, classism, heterosexism, bias, and discrimination further plunging black women into the margins of healthcare. This chapter holds the stories from eight women who share in their own words how they experienced mistreatment in healthcare based on their own definitions of mistreatment. For some, mistreatment is defined by violent physical or psychological harm. For others, mistreatment simply involves a woman feeling a judgmental white gaze upon her black body. Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena each live vastly different lives, representing the breadth of diversity amongst African American women. Some are married, some are mothers, some are queer, some are millennials, some are bi-racial. Yet similarly, they are all well-educated, they are all professionals, they are all involved in their Southern Californian communities, and they all have a story to tell.

What may constitute as mistreatment in their lives may not be considered mistreatment in the lives of others. The women defined mistreatment for themselves and shared stories based on their own definitions. They were not limited in what they could share or how they could define the idea of *mistreatment* within the context of the healthcare system. Their definitions and their stories were birthed from their experiences, their education, media, and awareness of the

collective cultural trauma inflicted upon their communities by the healthcare systems they rely on. The eight narrated stories told below are living human narratives. They are to be read with respect and trust rather than with critique and questioning. The narratives are organized to flow starting with chronic illness diagnosis and management, to reproductive and maternal healthcare, finally to mental healthcare and support.

Chronic Illness

Alicia - “The White Women’s Disease”

A sixty-three-year-old grandmother of five, Alicia spends her days engaged in United Church of Christ denominational board meetings, writing for speaking events, and fundraising for the National Multiple Sclerosis Society. She is an educator, an award-winning activist, and known to give a sermon or two. Her home smells of yummy treats baked from scratch but she and her husband of over forty years are sure to eat vegan during the week. Alicia now lives in a small city nestled in the Temecula Valley – but her story begins while she lived in San Diego, just forty-minutes south. Alicia and I began our conversation in her kitchen while she stood at her refrigerator filling a bright green cup. Balancing her ice water in one hand and her handcrafted wooden cane in the other, Alicia began her journey to the living room. I slowly followed, hoping to keep a respectful, unrushed distance. We take the twenty-step path through the kitchen, past the framed photographs of mothers and grandmothers, and turn to be greeted by two plush maroon chairs. Alicia does not simply sit in her chair, she reclines. I sit next to her, patiently waiting for her to settle in while I rummage through my notes. Finally, Alicia turns and says, “Okay.” I turn on my tape recorder and click my pen, eager to hear her story.

I asked Alicia to describe *mistreatment* out of her own experience. Alicia briefly avers, “In my opinion, mistreatment is when the medical community does not listen or value the

information that you share as the patient.” Mistreatment leads to feeling dismissed and disregarded, aware of the provider’s insufficient regard for the patient’s knowledge of herself. Mistreatment is neglectful, dismissive, and devaluing. Alicia’s experience of mistreatment coincides with her life-changing diagnosis of multiple sclerosis:

Late in 2003, I had an experience where my right side went numb. And this lasted for several weeks. I went to the doctor, I had an MRI, but nothing was diagnosed. Time went on and probably about four months later the numbness finally subsided but then came back. But, it was worse because not only was the right side numb, but the left side went weak. Going back to the doctor, I was told that maybe its arthritis of my neck. Maybe it was something else. But I was not given any definite diagnosis. This was around May of 2004. Time went on... things got better, but they didn’t actually go away. There was still some numbness, there was still some tingling. So, again, going back to the doctor trying to find some answers.

Finally saw a second neurologist and it was October of that year that I was given the diagnosis of multiple sclerosis. Very little information was given to me as to what that meant. I was given information on a treatment suggestion. But, I was told that it took so long to come up with this diagnosis because of my age, and of my ethnicity, because, “*black women don’t get MS*,” was how it was put to me. I cannot help but wonder, if maybe I was diagnosed sooner, and put on medication sooner, I might have had better results.

With a sarcastic pitch in her voice, Alicia mimicked the physician who uttered those words – whom she describes as, “Personality of a rock. And I say that because there was no compassion when he gave me the information. He sat across from his desk and just spoke.” The myth that *black women don’t get MS* crept into Alicia’s care and carried vast consequences. Alicia speaks to how those words, uttered by an older white uncompassionate neurologist, colored her interaction with other healthcare providers she encountered:

It was not too long after that that I ran into the person who was my general practitioner at the time that this all started. A woman, who had left practice because she contracted cancer. But I happened to run into her at the lab or some place, I can’t remember where. And she asked me whatever was the diagnosis. And I told her. And she stood there and looked me in the eye and said, “That’s what I suspected, but, didn’t want to say anything.” And, I have to assume, again, that she didn’t want to say anything because black people weren’t supposed to get MS.

In those days, multiple sclerosis was known as the White Woman’s Disease. It mainly affected blonde hair, blue-eyed women from northern areas of the country, the

world, whatever. So, therefore, people, medical people, were not even looking for the impact or the diagnosis in people of color. And, it was said to be between women of 20 and 40. At the time I was diagnosed I was 48. And, again, being a black woman, you know, so that's two things in my opinion that were reasons that they delayed in diagnosing.

In the beginning I was angry, because I think as a woman, [the physician] could have paid more attention to my symptoms and worked a little harder to try to find the answer when she thought she had the answer. In my opinion, it was her job to speak up and not be silent about this just because she didn't think that it could happen.

Alicia centers her story around the myth that *black women don't get MS*, words that echo frustration and suffering as in fact, black women like Alicia, of all ages, do get multiple sclerosis, and such a myth prevents timely action for diagnoses. At the present time, there is no cure for multiple sclerosis, only therapeutic treatment that aims to slow progression and palliate symptoms. Alicia notes that the earlier one begins therapeutic treatment, most commonly in the form of disease modifying injections, the better one's long-term prognosis. Over her now sixteen-year journey with multiple sclerosis, Alicia gradually experiences significant mobility challenges that worsen overtime. For the majority of those years, Alicia used a variety of injection medications to mitigate her symptoms, injections that alone pose health risks. Her story of mistreatment extends beyond her experience with uncompassionate neurologists and delayed diagnosis to her interactions with emergency paramedics called late one evening when Alicia experienced a negative side effect of her medication:

One night, after giving myself the injection, which was the disease modifying therapy that I was given, I had a very bad reaction. My husband called 911. The fire department came. The paramedics came and took me and, in the process, one of the paramedics, a white male, which everybody – the firefighters and the paramedics were all white men – asked me: what did I take? Told them that I took the medication that was prescribed, that it was in the refrigerator, that's where the vile was. [The paramedic asked,] "What else did you take?" [I said,] "Did not take anything else."

We're on our way to the hospital, in the ambulance and this gentleman kept asking me, "You must have taken something else. What else did you take?" As though I was a drug addict or something and that I was hiding something from him... that showed a lack of sensitivity on his part, again, not knowing if his mentality was, *well, black women don't get MS, so that can't be it, so you must've done something*, I don't know,

but that was how I internalized it. And, as we got to the hospital and as I tried to complain about this person I felt like I was brushed off.

The myth that *black women don't get MS* haunts Alicia and her encounters within the healthcare system. Those words caused immeasurable harm and transformed the way she engages, views, and makes meaning of her healthcare experiences moving forward. Alicia experienced mistreatment in her first neurologist neglecting to share that she suspected Alicia's symptoms of numbness and weakness to be multiple sclerosis. The neurologist *looked Alicia in the eye*, and explained that although she expected the diagnosis of multiple sclerosis, she refrained from saying anything at all. Dayna Bowen Matthew describes the physicians' behavior as statistical discrimination involving "a physician misusing and misapplying factually accurate information to reach an inaccurate conclusion concerning the specific patient."¹⁴⁷ She attributes these inaccurate conclusions to the physician's stereotypes about the race or ethnicity of the patient and these stereotypes in turn trump the patient's clinical information.¹⁴⁸ Should Alicia have presented as a white woman between the ages of 20-40 with the same symptoms, it is difficult to avoid the assumption that the first neurologist would have quickly diagnosed the patient with multiple sclerosis and begun treatment almost a year prior. Alicia's second neurologist put words to the myth the first neurologist followed. In a cold dismissive manner, the doctor told Alicia that *black women don't get MS* which is why it took appointment after appointment, and scan after scan, to find the diagnosis. This myth had the potential to cause untold harm to Alicia. Biases and dismissiveness delayed her diagnosis for already too long. Her

¹⁴⁷ Matthew, *Just Medicine*, Kindle location 1892.

¹⁴⁸ Matthew, *Just Medicine*, Kindle location 1892.

only treatment options unfortunately caused more harm, and the paramedics called to assist her enacted suspicion and prejudice.

Alicia's story is the first story in this collective of narratives as hers is a story I heard before – a story that haunts me as I watch African American women engage the American healthcare system. A story that erupted a wave of questions, fears, and reflections about the treatment, or mistreatment, of African American women patients. Hers is the story that began my own journey to find, listen to, and share the stories of African American women who have a story to tell. Hers is a story that sparked a journey to reflect on, engage, and theologize about the lived experiences of African American women who seek health care only to find dis-ease. And, although Alicia's story is her own, her experience blends into a wider, deeper narrative of African American women mistreated by those they trust to treat them well, and their spiritual process of making meaning out of their mistreatment.

Stacey - "A New, Unfamiliar Doctor"

Sitting at her dining room table, Stacey joined our video call to tell her story. The thirty-six-year-old wife and mother of two recently began working from home while homeschooling her children during the pandemic. During our call, she kept her sons occupied with makeshift homework assignments and carved enough time out of her busy schedule to offer two experiences of mistreatment. Stacey's busy schedule not only revolves around developing a new normal in her family life, but her career often takes center stage. Stacey is the senior vice president of a policy and legislative think tank, hails from an Ivy League university, and is establishing herself within local and state politics. When not traversing her promising legislative career, Stacey serves as PTA president, runs a prison outreach ministry at her church, and raises

chickens in her backyard. She embodies care, justice, and service and her devotion to her family mirrors her devotion to her community.

Stacey's legislative work centers around creating just policies for low-income communities and communities of color across the country. She prioritizes those who often experience disadvantageous recourses for national policies that privilege white, middle-class and employed Americans. Her unique political perspective, her advocacy for ethical legislative practice, and her work on the ground with underprivileged communities undoubtedly contributes to her view of mistreatment within the U.S. healthcare system. In her words, she describes mistreatment as:

A lack of care and concern for persons' emotional wellbeing, especially if it's a result of a person's skin color or the way that they present themselves to a doctor, physician. Even though you may get the healthcare that you need, it's not in a way that feels safe or comfortable or that you feel like you were truly heard.

For Stacey, apathy, dismissiveness, discomfort, and threatened safety define the experience of mistreatment for African American women. In her daily life, Stacey advocates for the underheard and often silenced – therefore, intentionally not hearing a patient's needs, concerns, and thoughts becomes a clear violation of their safety and comfort. With this in mind, Stacey shared two stories that highlight her characterization of mistreatment.

When I asked Stacey to share her story, she began with a story from seventh grade. Although the project sought to collect more recent narratives from the participants' adult lives, Stacey sprung to tell this story with a rhythmic ease. When I asked her to share her story, *this* was the story that came to mind – our interview becoming a stage from which Stacey could finally sing her tune. Instead of wondering how her story would fit into a broader narrative among the others, I chose to get out of her way and allow her and her story to take centerstage:

I think I've had a lot of circumstances and the earliest one that comes to mind is when I was in seventh grade. I got really, really sick and I didn't know what was going on. My mom took me to, I think, urgent care because it was an unfamiliar doctor. It was an older white man and he kept asking me who I'd been kissing and trying to get - it was to the point, like, I still remember it, because it was like, over and over and over again he would ask me, "Who have you been kissing? Have you been kissing? It's okay to tell me. Tell your mom. Just tell us who you've been kissing." I was in seventh grade, and back then I was innocent. I never kissed a boy. Like, what is going on? So, I didn't answer him, which I think made them feel like I was hiding something, 'cause he kept pushing. And I was just so uncomfortable and my mom was in the room. That was like my first experience of feeling truly uncomfortable in a medical setting. Turns out he thought that I - he assumed - that I had mono, I did not. I had strep throat. But, that's why he kept asking who I had been kissing... I thought that maybe because I was young and black and developed that maybe he thought that I was promiscuous and that I was making out with boys and kissing boys and doing other things with boys so that I would have caught mono which is physically spread through kissing or swapping saliva.

Stacey's story wreaks of stereotyping, sexism, and suspicion. And perhaps Stacey presented with symptoms of mononucleosis, or *mono*, but, she also presented with symptoms of strep throat, her diagnosis. The physician focused primarily on the disease of mononucleosis, rather than exploring other possible pathologies. Stacey believed that his focus on mono was based in the assumption that she, being a young post-pubescent black girl, must have had sexual experiences with boys. The physician grew increasingly suspicious of Stacey who denied any kissing experience. Stacey felt both unsafe and uncomfortable during the encounter, becoming the first time she remembers experiencing mistreatment in a healthcare setting.

Many years later, Stacey had a different experience with another physician. This time, rather than questioning her with suspicion, this physician dismissed her symptoms ultimately resulting in a misdiagnosis:

I mean the diagnosis of my IBS [irritable bowel syndrome]. That's like my one major health concern or issue. So, it was right after college so I was away from home. I went to a new doctor, again. I think, I don't know, maybe that's the trend, a new unfamiliar doctor. She was a white woman. I was having a lot of pain and she didn't even fully examine me. She asked me some questions but she basically told me I had hemorrhoids and gave me a prescription of hemorrhoid cream. And she was very dismissive and curt with how she was speaking with me. I felt like I was bothering or like I was annoying her

with my questions. I think I even recall her like rolling her eyes at one point. Turns out she misdiagnosed me completely. I did not have hemorrhoids. The medicine that she gave me didn't work so I had to go back to her and tell her like, I still have a lot of issues. So, then she ended up referring me to a specialist and it turns out that I actually had a tear in my skin and needed surgery because my stomach was so compacted that I couldn't use the bathroom properly and so, it's causing all kinds of issues. And so, that's how I eventually ended up with my diagnosis of IBS. But, to think like, I was completely dismissed by the first woman, and she was just like, it's probably hemorrhoids, here's some cream, and go deal with it – to seeing a specialist who's like no you actually need surgery, this a big deal, kind of crazy.

It was in Santa Barbara, which was where my college was, and I probably recently graduated and was still working on campus and so she might have made the assumption, and I'm guessing, but she might have an assumption about me being a college student and like just not really knowing what I'm talking about, not being able to describe my own condition, what I was feeling. Because, I mean, I didn't know what was going on, it was completely new to me. All I knew was that I can't go to the bathroom. It hurts. I don't know what's going on, I'm having a lot of pain. It was a completely new experience. But, instead of trying to dig into that, she just kind of brushed it off, as maybe like, I didn't really know what I was talking about.

The physician chose not to examine Stacey despite her symptoms, resulting in a misdiagnosis and improper treatment. Stacey felt dismissed, describing the physician as curt with rude behavior. Stacey contributed the physician's actions to the assumption that Stacey's youth indicated the inability to know her own body and describe her pain experience. The physician's assumption had potentially disastrous consequences as Stacey ultimately needed surgery.

In both of her stories, Stacey experiences what she describes as, “A lack of care and concern for persons' emotional wellbeing.” During each encounter she felt her safety, her comfort, and even her voice was of low priority to the provider. Matthew explains a physician's process in making a diagnosis involves the physician accessing previously stored knowledge including medical school training and clinical experience.¹⁴⁹ Matthew argues that if the physician's stored knowledge includes biases and stereotypes about the patient, “the physician may mistakenly interpret a minority patient's data in ways that would not occur when

¹⁴⁹ Matthew, *Just Medicine*, Kindle location 1937-1947.

interpreting a white patient's data.”¹⁵⁰ Stacey experienced dismissiveness, suspicion, and being stereotyped as a promiscuous seventh grade girl who simply needed care for strep throat.

Tamika - “You’re Supposed to be Providing Me Care? You Don’t Even Care for Yourself”

A prolific poet and pastor, Tamika never shies from speaking openly about the experiences that formed her. Tamika often shared about her long journey with kidney disease, her difficulty finding a donor, and the toll the disease process took on her body. When I approached her for this interview, she expressed excitement and gratitude for being able to further share her story, not about her illness or recovery, but about her treatment as a young differently-abled African American queer woman navigating the healthcare system. Tamika is a thirty-two-year-old pastor living in the Los Angeles area. She is a spoken word artist with a master's degree in divinity, often thoughtfully playing with the intersections of black life and Christian faith with her rhymes. Her compassion, kindness, and optimism, even during her own pain and adversity, left her nationally acclaimed as an advocate for peace.

We met over a video call on a sunny weekday afternoon. With COVID-19 continuing its rampage through the country and particularly destroying black lives, we spent the first few minutes checking in with one another and acknowledging the shift. As one of my final interviews, I reflected on the difficulty of collecting these stories whilst in a global pandemic disproportionately devastating the African American community. But, in our interview I found the energy to push through as Tamika eagerly began to share her story. As in the other interviews, I asked Tamika to share how she defines mistreatment in her own words:

Tamika: I struggled with the care that I received most of the time. Never really knowing if I was going to be heard or seen and catered to in terms of what was coming up. A lot of times, what happened is, I felt like a research project, like they were trying to get to the

¹⁵⁰ Matthew, *Just Medicine*, Kindle location 1937-1947.

bottom of why I got the kidney disease versus dealing with some of the other symptoms that were more immediate in my concern. I have a lot of examples is that okay?

Jessica: Yeah, absolutely.

Tamika: Cool, so, one example is, I couldn't breathe. Like, something was happening all in here where I couldn't breathe. And, wasn't necessarily sure that it was kidney disease related, but when I went to the hospital, got admitted to the hospital, they were kind of running all kinds of tests around the kidneys and I'm like, this I don't think is coming from the kidneys, like, I need to breathe. Even to the point that they prescribed me a pain medicine I asked them not to give me – a narcotic I asked them not to give me – in the midst of my pain unaware of what they were giving me – gave it to me. And, I'm literally sitting in the bed all night feeling like I'm spinning in circles, spinning in circles, spinning in circles. Anyway, I stayed in the hospital an entire week, and the condition where I could not breathe was not addressed. So, I had to leave. I had to discharge myself. And just through personal – listening to myself and doing some research, went to the chiropractor and they were able to help me with some of the issues that were coming up. So, my treatment – it's kind of depended on where I was in the system.

Even in her brevity I heard notes of mistreatment in this story. I heard dismissiveness, apathy, and perhaps even negligence. I hoped to further expand on this story as it seemed full with themes to further unpack. However, I remembered she indicated she had multiple examples of mistreatment that she hoped to share. "Is there another example that you want to share?" I inquired. Immediately, she responds,

Sure. So, there was one situation where – I don't know what they would call it, but it felt like a nervous breakdown, where literally I couldn't stop twitching, kind of, doing this very abnormal movement, and ended up in the hospital. Shortly after, the nerves in my leg went out, wasn't able to get up and walk. And, that night the treatment was very distant, very *we don't know what to do with you*, very *we're just going to knock you out and hope that helps*. And it did, but it was really, *we have nothing to help with these symptoms right now*.

There was a time where I had sludge in my spleen, and the doctors couldn't figure out what was wrong with me. It actually took the nurse just kind of probing and asking questions and touching my side to be like, oh, that's what that is. So, sometimes feeling very dismissed, laying there for days, no one figures anything out. And then, there comes an angel nurse that's randomly doing their job extremely well. There's one times I had two ribs pop out of my back, don't ask me why. Doctors couldn't – nothing! Didn't know what to do, how to deal with it. Went back to the chiropractor, had to have those ribs popped back into my body. So, it just depended.

Tamika's treatment in the healthcare system varied based on her medical need at the time. She often felt like an anomaly, watching as medical providers gaze upon her complexities with no

solution to ease her suffering. Tamika inexplicably developed kidney disease at a young age, resulting in kidney failure, a weekly dialysis regimen, and a long wait for a kidney donor. Tamika found difficulty in defining mistreatment because she experienced so many different forms of treatment in her health care. She remarked, “At the dialysis clinic, I got treated very well, more of a personable kind of feel. But, when it was time to go to the ER, it was hit or miss. It depended on what condition was coming up for me, the immediacy, and even the treatment sometimes that I was given.” Her experiences were often as diverse as the symptoms she presented with.

I hoped to continue our interview by deep diving into only one example and asked her preference on which story she would like to further unpack. Tamika was an open-book, and together, we chose to talk more about the first vignette; a story about a black body fighting to simply breathe while those she trusted neglected to help. Her opening statement, “I couldn’t breathe,” mirrors the words of Eric Gardner who declared, “I can’t breathe” to the police officer restraining him in a chokehold. Only forty-two days after our interview, her statement now mirrors the words of George Floyd, who cried, “I can’t breathe,” to the police officer kneeling on his neck for nearly nine minutes. Perhaps, this is why the first story captured my attention. I asked Tamika to expand on her experience:

So, the frontal staff, they’re always pretty pleasant unless its busy. You know, if it’s a slow night, everybody’s kind of nice and making sure I have the wheelchair to be wheeled in. And also, when you go in with chest pains, they’re much, much quicker with the process. So, that particular night – and I had terrible, terrible anemia, so I was always very cold and shaking during these experiences. The main player was the doctor they assigned to me who I believe was on drugs. Just her affect, things she was doing with her face. Sorry, it’s a little graphic, she was licking her nose. Yeah, she was the main player that didn’t provide great care. Her interns were kind of all over the place and not listening to me, probably due to her and her instructions. And so that was just not a very good experience for me. I may have had a few nurses in and out that were very caring, and thoughtful, but that lead doctor, because of how she was showing up, was out of control. Wanted to tell my parents that I was lying about the medication that they gave me. When

in fact my partner had went and asked the nurse, “In your records, does it show that she received this particular drug?” And, the doctor had given it to me... It was terrible! My parents were kind of like, our child is not a liar and something is wrong with you. So, that main player, that doctor in particular, is who I had to see day in and day out. It was nasty.

Tamika further explained that the physician was a white woman who seemed more concerned with exploring Tamika’s underlying kidney disease than her presenting breathing concerns.

Tamika often believed physicians looked at her with a gaze of suspicion – treating her as a mystery needing to be solved or a medical anomaly needing to be researched. Because Tamika’s diagnosis came unexpectedly with no clear pathology, physicians often focused on why such a young and previously healthy woman developed kidney disease. Any other symptoms or health concerns she presents with to her local hospital’s emergency department are whisked away and dismissed in favor of researching kidney disease. Tamika felt ignored as her breathing concerns remained untreated. As she told her story, she began to process other experiences with similar physicians:

If I think about a few of the white women and their treatment, it was kind of the same. Kind of condescending at least in the beginning, before they really spoke to me, or knew my background or heard about my accomplishments. Then in comes my entire family, family unit, and they hear I’m a pastor and I’m in school... it was almost like I had to pass some test. All of my intersections in their mind made me less than and not enough. Then they see, oh you have decent insurance, alright, that’s another way we’ll categorize how we’re going to treat you.

As a black queer woman, who at the time found myself extremely poor because I was unable to work, I feel like that’s how they addressed me in the beginning. Well, especially that lady. And, I even remember when she tried to pull that whole, I’m lying, and I’m this and I’m that, I told that lady to her face, “Look, you are the one that is not well, and I don’t appreciate you lying to my parents about me because they know the truth. And, that’s why I’m leaving your care immediately.” ... I could clearly see she was on drugs and something wasn’t right with her. And you’re supposed to be providing me care? You don’t even care for yourself. So, yeah that was always a bad feeling to have.

Briefly mentioned, the physician accused Tamika of lying about the medication she was given and chose to portray Tamika as untruthful to her family. In that moment, Tamika

experienced the weight of the physician's mistreatment, as the physician enacted her assumptions that Tamika's parents would believe she lied. The physician painted Tamika as unsure of her own body, unsure of her medical treatment regimen, and untruthful about her treatment – or, said differently, Tamika experienced gaslighting. Her mistreatment summarized by feeling ignored and stereotyped, prompted Tamika to search for alternative treatment options to find relief for her chest pain:

I guess maybe the second-to-last night or the last night, dealing with the hospital, in terms of the lack of treatment and my breathing and helping me to figure it out, I looked online that night, don't ask me why, but I looked into structural pain in the body. I think I googled something like, chest pains that aren't caused from blah blah blah – something random. And it was like, oh you might need to go to the chiropractor. You might need to try alternative medicine to get this pain relieved. So, it was literally a google search because they couldn't do it. They couldn't get it. And, when I went to the chiropractor. Literally after leaving that forty-five-minute session I could breathe again.

Tamika chose to leave against medical advice to see her chiropractor. She chose to make the best decision she could for herself in the midst of her physical pain and frustration with the traditional medical system. Tamika needed relief and could no longer wait for the hospital physician to finally attend to her concerns. Tamika chose to take her treatment into her own hands and left the hospital that night.

Tamika encountered dismissiveness as the medical team assigned to her chose to focus primarily on her underlying kidney disease, ignoring Tamika's consistent and pained declaration that she could not breathe. Tamika hoped that her local hospital would be able to assist her with her presenting concern of chest pain. Instead, she felt like a research project for a physician she experienced as far from professional. This physician also chose to label Tamika as deceptive, telling Tamika's family that she lied about being administered a certain medication. Matthew reports a Harvard study that concluded, "white physicians hold implicit racial biases against African Americans, associating their black patients with negative attributes such as being

generally uncooperative and medically noncompliant.”¹⁵¹ Tamika felt that same gaze from her physician and understands these actions as based on the doctor’s biases and assumptions about her as a queer black woman. Likewise, Tamika carries the assumption that the medical community viewed her as an experiment, needing to be researched. Harriet Washington reminds us that due to rather recent historical occurrences of non-consensual medical research in the black community, “no other group as deeply mistrusts the American medical system.”¹⁵² Townes reminds us that racial-ethnic women have been particularly targeted for social-problem research, high-risk clinical trials, and non-consensual experimentation.¹⁵³ For Tamika, her concern for her well-being, her safety, and her care were justified. In addition to her concern of experimentation, both dismissiveness and bias performance contribute to Tamika’s mistreatment during this hospitalization.

Reproductive and Maternal Healthcare

Opal - “Just the Baby Momma”

Southern California was in the thick of the COVID-19 pandemic when I interviewed Opal. The week of our interview, it seemed the entire country began to awaken to the realities of the pandemic’s impact on African American communities. Social media influencers, news outlets, community leaders, and even President Donald Trump spoke directly to the ways the pandemic uncovered – or, rather simply highlighted – significant disparities in health, healthcare, and capitalistic social structure. COVID-19 proved to be more lethal in patients with

¹⁵¹ Matthew, *Just Medicine*, Kindle location 1290.

¹⁵² Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (Harlem: Harlem Moon, 2006), 5.

¹⁵³ Emilie M. Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care* (Eugene, OR: Wipf and Stock Publishers, 2006), 115.

comorbidities such as diabetes, heart disease, and asthma – all illnesses disproportionately prevalent amongst African Americans. These higher rates of comorbidities further pointed to deeper equity, class, and environmental issues steeped in racism and a historical precedent of inequality. Likewise, COVID-19 cast light on the working class; on one hand, proving that those deemed essential to work during a national emergency were often black and brown people risking their lives on the frontline for consistent employment; and, on the other hand, placing low-income, under-insured, non-essential employees into the despair of unemployment during a catastrophic recession.

Opal joined our video call from her home office in the San Diego area. With two young children, a full-time job, and a fitness training side hustle, this thirty-three-year-old military spouse always has her hands full. Opal carries a presence of power and inspiration as her service and engagement in the black community of San Diego motivates those around her. Opal's ability to balance her family, career, and social life astounds me, she could quite possibly, take over the world. But, our first few minutes of conversation brought me back to the harsh realities of our current global climate. Opal shared that just a week before our interview, she tested positive for COVID-19. Acquired from her husband, an essential member of the U.S. military, Opal spent weeks quarantined in her home with her family, fighting a devastating virus, and homeschooling and mothering her daughter and son while trying to keep them healthy – all while continuing to work from home. Her perseverance left me with a strange grief as my mind gathered the proverbial long list of black women with no other choice but to persist in the midst of chaos and suffering for the survival of themselves and their families.

In the midst of her mothering and her teaching and her working and her healing, Opal took time to share her story of mistreatment. For Opal, mistreatment is categorized by “the lack

of empathy, the ‘okay, let’s just get this over with.’ The hurriedness when it comes to a woman of color, versus actually taking the time to actually listen.” Mistreatment occurs when apathy and dismissiveness are present within the care encounter as care providers refrain from listening to their patients, leaving them feeling rushed and disregarded. As the pandemic places a national spotlight on the general health and healthcare of African Americans, Opal’s story of mistreatment prompts reflection on another simultaneous national pandemic – black maternal mortality/poor black maternal healthcare:

So, I had my daughter in June of 2014. Hold on one second... *[A fitness training client instant messaged Opal. She muttered under her breath as she quickly typed on her computer and chatted with her client, hoping to quickly bring their conversation to a close in order to return to our interview.]* So, I had my daughter in June of 2014. I actually ended up having her a week early, so I had her at 39 weeks. During that period, we were actually PCSing *[sic]* (Permanent Change of Station) from the East Coast to the West Coast. So, my primary care doctor, primarily during my pregnancy was on the East Coast. And, just even with *[my local hospital]*, one of the appointments that I had, one of the midwives actually told me, no it wasn’t a midwife, it was a nurse, ‘cause I had the little doppler thing where you could listen to the baby’s heartbeat, told me not to use that to basically check the heartbeat at home because she had a patient that had one and the baby had died... there was no empathy, especially for a first-time mother.

Then when it comes down to me finding healthcare out here, being very pregnant with my daughter... I had to automatically go to *[the local military hospital]* because it was really within that time period of, I didn’t have enough time to get to know a doctor, transferring from the East Coast to the West Coast, to new out here, being a military spouse so, you kind of have to go through that. So, each time I went to *[the local military hospital]* I saw a different doctor. It was no one consistent. Then... I ended up going into labor at home, at the 39-week mark. We were actually in the pool and I actually went into labor. We get to the hospital and because I wasn’t dilating like I was supposed to, so they had to induce me to get my cervix to basically open up. By inducing me, of course I get admitted. So, throughout that they’re like, “Do you want your epidural?” So, finally the individual comes in with the epidural. Now, mind you, the individual that came in was the doctor, not a student. *[The doctor is]* like, “Okay, well, we’re going to administer your epidural,” and I explain to her, “Okay, I have scoliosis, I actually have two curvatures in my back.” So, one, she should not have allowed a student right then and there, as soon as you hear the word scoliosis. Two, they didn’t ask my permission about allowing a student to do it. I found out that a student did the epidural from my husband because of the scared look on his face. And, I asked him afterwards, he’s like, “yeah, that was a student that did it. The doctor didn’t do it, she was just watching her.” And you didn’t stop them? *[He]* said, “Well, they had the needle already in your back...” Then when it came time for the catheter, because your epidural’s supposed to go in first so you

can actually not feel anything, still was feeling everything. Like, I was screaming in pain. And, they wanted to try to jam the catheter in me and didn't want to listen. So, I had to actually ask for a supervisor to come in and then they had to actually use like, a numbing gel, or whatever, to do the catheter.

So, going through the labor pains and everything else with that. It got to the point where I can actually feel my body start to push the baby out. They're like, "No, no, you're not dilated yet. No, you're not dilated yet." They wouldn't even check me. And finally, I'm like, "No, you need to check." And, then they checked and they're like, "Oh, we see her head." I shouldn't have to tell you when something's coming out of my body, you're supposed to be checking me right? So, ended up pushing my daughter out in four pushes.

They get me cleaned up and everything else and they're like, "Okay, we're going to take the baby away so she can go do all her tests and everything else and we're going to start getting you prepped to go to your recovery room." So, they start ripping all the stuff out, or whatever, my IV. And my legs are starting to swell. Didn't even care. Like, I literally was discharged from the hospital within 24 hours. They didn't even check on my legs, no nothing! I'm like looking at them like, my legs are swollen. This is not supposed to happen. They're like, "Oh, that's just water retention from because you were just laying down." You still need to check my legs, I never had any health issues besides scoliosis before.

Opal's birthing story of her daughter is fraught with layers of subpar care. She notes inconsistent physicians throughout her prenatal care and delivery. She avers,

Now, mind you, the individual that delivered my daughter, she was female, however, I had two doctors throughout the entire labor and delivery process. I started with a guy doctor, and then they switched doctors. [The guy doctor said,] "Oh, now she's your doctor because I'm going off."

She also notes the difficulty she experienced with the administration of the epidural. A provider, whom Opal notes as a medical student, attempted to administer Opal's epidural three times.

Opal's scoliosis warranted careful intention and placement of the epidural, care and intention she did not experience with the student's attempts as well as her lack of consent in allowing the student to administer the epidural in the first place. Because of the epidural's faulty administration, Opal felt her catheter being jammed into her body causing severe pain. Her use of the term *jam* invoked a careless penetrating violation of her body. Once Opal began to feel her body pushing out her baby girl, the care providers denied Opal's experience with suspicion and

mistrust until of course, examining for themselves. Following her delivery, Opal was further dismissed as she sought care for her swollen legs. As a first-time mother, any education, examination, or even empathy, would have quelled Opal's worry and curiosity for her new symptoms. Instead, she was dismissed and rushed out of the hospital doors. "They didn't even do the lactation consultant at [the military hospital]" she says, "I literally had to do it on my own. I had to figure it out as a first-time mother."

Opal's care team was primarily white, although some nurses she encountered were Filipina. Our conversation turned to the assumptions of the providers holding her in their care:

Opal: I don't even think it's even just the race or identity too. I know with [the military hospital], 'cause it's a military hospital, they also look at what your spouse's occupation is too. Or what their rank is. And the reason I say that is because as soon as they saw that my husband was special forces, they changed their attitude. So, if you're a special forces spouse, or you're an officer spouse, they'll change their attitude. But, if you're just a regular enlisted, they can care less.

Jessica: Interesting. And, even with that attitude change, they still didn't treat you the way you should've been treated the entire time.

Opal: They didn't give the level of care they should have treated me with. Like, yes, they changed their attitude a little but, like, okay let's start asking questions. But, you shouldn't have to look at someone's record, to say oh, that's such and such's wife. Or, that's such and such. Or, that person has this rank or whatever. Everybody should be treated the same across the board regardless of color, race, creed, gender, or whatever [she pounded her desk with every word as if to hammer in her beliefs of equality and fair treatment].

Opal's experience as a military spouse provided a different perspective on the lived realities of African American women. In addition to facing the uphill battles of race, gender, and class oppression, Opal also contends with stereotyping, prejudice, and biased assumptions within the military system. This quartet of barriers gave Opal privileges, at times, in certain areas of her life, while at other times facing disadvantage. Her husband's rank dictated the level of care she received, providing her a privilege within the military hospital system, yet Opal's privilege is attached to her identity as a spouse – a wife – within a system of deeply rooted patriarchy.

Despite her husband's rank, her identity as a black woman incited other assumptions to be carried out in the midst of her care:

Opal: I think they probably had the assumption that okay, maybe she might be a baby momma. 'Cause, we always get that. Versus actually, oh, wait a minute. That's actually a wife. She's not one of the other single women out here who just had a baby, that's the baby daddy. I really do think those were the assumptions, because I actually heard it.

Jessica: What did you hear in particular?

Opal: "Oh, I wonder if they're really married or if she's just the baby momma." Like, I can't get treated here if we're not married. What part don't you understand of that?

Black maternal mortality in the United States is at a catastrophic high. Unable to explain a biological explanation of why black women experience a disproportionate rate of death as compared to other groups, many researchers point to the reproductive healthcare for African American women. Therefore, a care provider's apathy, dismissiveness, and suspicion contribute to poor health outcomes of African American women who seek even basic obstetric care. Furthermore, Opal expresses considerable distress around the military hospital's status as a teaching hospital and the student's administration of her epidural. Washington notes, that even today, a part of medical schools' marketing strategies is to have socially complex patients, such as poor patients of color, for students and residents to see.¹⁵⁴ Opal's discomfort in the attending physician allowing the student to administer a spinal injection in a scoliosis patient caused immense frustration and prompted mistrust. Opal's care faced inconsistent oversight, dismissal of her symptoms, and suspicion of her body-knowledge with each form of mistreatment potentiating devastating psychological and physical harm. Nevertheless, Opal and her daughter survived their birthing experience despite mistreatment in the delivery room. Six years later, Opal and her family survived COVID-19 plummeting through their home. Opal's delicate balance of her work, family, and social life, even in the midst of chaos and uncertainty, mirrors

¹⁵⁴ Washington, *Medical Apartheid*, 107-108.

her balance of her race, gender, class, and spouse's military rank – identities that dictate her healthcare in the midst of global and national pandemics alike.

Tarana - “Why Do You Smoke Weed?”

Tarana joined our video call energetically sharing frustration about her health insurance. After being let go from her most recent employer, Tarana began navigating social services including unemployment benefits and Medi-Cal. Although she lost her job before the pandemic, the economic status of the country resulted in a hiring freeze, leaving Tarana unable to find stable employment for months. Tarana is a 30-year-old college-educated Los Angelino with a heart as big as her personality. Despite her positivity and openness, Tarana's life rings of difficult moments she endured to become the woman she is today. Tarana describes her biological mother as sex-worker struggling with addiction who used crack cocaine during her pregnancies, leading Tarana and her siblings to be adopted at a young age. Her adoptive parents nurtured Tarana and instilled within her a deep pride for her life, her blackness, and her community. Tragedy struck a few years ago when Tarana lost her father to cancer. Serving as his caregiver, Tarana came face-to-face with the healthcare system and witnessed what she recognizes as apathetic and inconsistent care. She grew weary as her role of daughter-caregiver was layered with the roles of advocate, fighter, and comforter as she worked to ensure her father's final days were filled with quality of life. After her father's passing, Tarana began to experience signs of post-traumatic stress disorder and subsequently began a much-needed relationship with a therapist as well as the use of medical-grade cannabis for anxiety, approved and monitored by her therapist.

Once Tarana lost her job, she lost her health insurance and her psychotherapeutic relationship and in the midst of COVID-19 and California's Stay-At-Home order, Tarana's

mental health began to fade. Her and her family's unemployment, the looming national recession, self-isolation, and the continued threat of one's own health and safety caused Tarana's symptoms of anxiety and depression to creep back into her everyday life. She desperately needed to re-establish psychotherapeutic support and explains, "I've been trying for months, Jessica, to get medical insurance. Just so I can remain some kind of sane and stable and get back to therapy. Because that is all I can really ask for right now." We spoke at length about our mental health suffering while in quarantine, the benefit of psychotherapy, and the frustrations of California's social services system, to which Tarana notes, she applied to Medi-Cal in February, was approved in April, but not told of the approval until the day before our interview – nine days later. Over her unemployment, her sixty day wait for Medi-Cal approval, and her desperate need for relief from her own mind, Tarana continued to rely on cannabis for mental health support. Although cannabis is legal both medically and recreationally in the state, California's medical community remains divided on – and often skeptical of – its use. This is where Tarana's story takes off.

About thirty minutes into our video call, I asked Tarana to define mistreatment. Our conversation was already so rich and full of energy, I almost forwent asking her any preconceived interview questions with the hope of continuing our conversation and bearing witness to what organically arose. Yet, I thought it critically important to understand her concrete definition of mistreatment as she continued her story:

I think one form of mistreatment, as you and I just discussed, is just all of the red tape and all of the loops and bounds that you have to endure just to secure basic healthcare services before you have even seen a doctor or any type of practitioner for that matter. I think that also when it comes to mistreatment in the healthcare center [*sic*] a lot of that mistreatment, at least for me, that I've experienced, is just dismissiveness of healthcare providers, or lack of empathy or sentiment.

Tarana understands mistreatment in the healthcare system in light of her recent difficulty navigating the Medi-Cal process as she describes the *loops and bounds* she went through for basic, minimal care. On a smaller scale, she points to dismissiveness and apathy as indicators of mistreatment from healthcare providers. Both dismissiveness and apathy play a role in Tarana's story that evokes the intersection of sexuality and race:

I went to a Planned Parenthood, one because Planned Parenthood is known for being a social service provider who empathizes or cares about women and their own right to their health service, so I support Planned Parenthood. But, I went in to obtain birth control. I had done the pill before, didn't really like it, didn't find that it was very helpful for me, as most women, 'cause if you forget it then you know you missed that dosage. I wanted something a little more dependable. So, I went in unsure if I wanted to do the patch or the shot, the [Depo-Provera] shot. Had done some research about it but really wanted some person-to-person, kind of, in my experience this is what I've seen and experienced, type of feedback. So, I got there, gave them my medical history all on paper form. Finally got called in and pretty much most of the information that I had provided on the paperwork that was in my file was not read. So, they asked me like my sexual orientation, gender, and there was a third question on the form. And when the [nurse] practitioner came in asking for like my sexual history, they were referring to my sexual history in a very heterosexual rhetoric when I clearly designated on my form that I'm bisexual. And, so, mainly geared towards my intercourse, or the lack of sexual history with men.

Most of the questions, although it wasn't even about birth control, they were just asking about STDs, were geared toward only heterosexual intercourse. Which I thought was very dismissive because you can contract an STD from any gender, and any type of sexual intercourse. So, for you to mainly focus on my intercourse with a man when at the time I was in a same-sex relationship, was completely irrelevant because I haven't had sex with a man. I'm in a same-sex relationship – committed relationship with my partner of, at the time, like many, many months. And so, the fact that I provided this information with you under this circumstance, and now you're coming to me, asking me questions about a heterosexual relationship – that's not what's reflected on my paperwork. I'm asking for birth control and so, you think, obviously, heterosexual. But, if I'm bisexual that means I can be having sex with both. And so, you're only specializing [sic] for either the STD that I might contract from a same-sex relationship that you're not really in the mental space for and asking questions about, or you're focused on the birth control aspect of a heterosexual relationship, which if they're asking for my history, wouldn't be applicable right now because I'm in a same-sex relationship. And have been.

Tarana grew frustrated with the assumptions of the nurse practitioner about her sexuality and the reason for her visit. Tarana connected the nurse's assumptions to not thoroughly reading the patient intake forms that Tarana filled out prior to the visit. Tarana sat in Planned Parenthood's

waiting room and extensively provided her medical history information on a clipboard stacked with paperwork – and the paperwork was never read. As a bi-sexual patient, Tarana hoped the staff of Planned Parenthood would be intentionally respectful of her sexuality and sexual history. She felt both her sexuality and her stated need for birth control – menstrual cycle regulation – were ignored and dismissed by the nurse practitioner and she ultimately attributed such dismissal to her identity as a black queer woman.

Tarana’s frustration grew as her appointment continued. Her visit turned from thwarting heterosexist questions about her sex life to justifying her use of cannabis for anxiety:

Furthermore, we’re going into the appointment, and the... practitioner asked me if I drank, which once again, on the paperwork it says no. So, I’m answering no.

“Do you smoke?”

“Yes.”

“Cigarettes or weed?”

“No, I don’t smoke cigarettes, I smoke weed.” She says afterwards, “Um, you know with the Depo shot, one of the side effects is weight gain. And you know, if you’re smoking weed, then that only will increase that chance. *Why do you smoke weed?*” And she said it in a very judgmental tone. [She said,] “You probably want to give that up then.” I told her, “Well, no I smoke weed because I suffer from anxiety and it helps to regulate my anxiety when I’m not on my meds, or any meds.” [She said,] “Oh, well yeah mm... well yeah just look out for that... yadda yadda” Well, wait are we here for the reason that I came in here for or are we here for a drug analysis. I’m not divulging the fact that I smoke this perfectly legal recreational drug within the state of California, that I obtained legally. Instead of focusing on my concerns about weight gain, and maybe telling me you know, what is your lifestyle as far as your diet, consider working out more, maybe consider eating less meat, like giving me that information and trying to advise me on those things, which I already know about because I’m interested in nutrition, you instead are trying to discourage and judge me about my drug use. Which makes me feel less responsive and receptive to you and like I don’t want to come back if you’re going to judge me. Or, like, I don’t want to divulge and be completely honest and open with you if I know you’re going to judge me.

Which at the time, weed was as it is now, I think, still legal in the state but federally illegal and it was like fresh, because I believe I had my appointment in February and it was at the beginning of the year January that it was recreationally legal. Okay, so we’re coming out of this social stigma of recreational use of marijuana, medical community has been marijuana use to their patients. We’re coming out of you needing like, a “rec card” [recommendation letter from a physician] in order to use marijuana. So, it’s not like the medical community doesn’t acknowledge the benefit of weed use.

But, now I'm also coming to you with even more sensitive information about my sexual history, not just my medical history, but my sexual history, and potential parent or family planning, which is what Planned Parenthood is about, and you are making me feel very uncomfortable and judged because I divulged to you that I smoke weed to manage my anxiety. Which is basically what you would be giving me prescription drugs for. So, do you want to help me? And help me help myself? Or are you just here to tell me what you think I should do, or how you think I should carry myself and my medical history. That doesn't really help... I didn't come to be assessed about my drug use. I came to be assisted for the service that you provide.

Tarana felt violated. She disclosed her cannabis use on her intake forms, and because the forms were not read, she further disclosed her use during the appointment to a healthcare practitioner she trusted to avoid judgment. Instead, Tarana faced judgment for her marijuana consumption and was subsequently asked *why* she smoked, pushing CT to justify her actions. The practitioner mentioned weight gain as a possible side effect of the Depo Provera shot and correlated an increased possibility of weight gain with cannabis use, particularly due to the user having the “munchies” after smoking. This further angered Tarana who exclaimed, “It’s like lady I know very well that smoking weed gives me the munchies. I’m there when I do it. And I’m there when I eat the snacks.” Tarana grew annoyed at the nurse’s perceived assumptions that she did not understand how to regulate her own weight, that she was not prepared for the consequences of the Depo Provera shot on her own body and lifestyle, and that her use of marijuana served recreational purposes rather than dire mental health maintenance. Furthermore, the practitioner never asked about Tarana’s frequency of cannabis use or if Tarana believed her own cannabis use was worth further exploring – she simply assumed her use was at a level where it would impact Tarana’s weight and needed to be further managed.

After hearing Tarana’s experience with the nurse practitioner, I wondered how her race and gender played into the nurse’s assumptions, particularly in reference to her marijuana use:

Jessica: Do you think any of her assumptions were because you’re a black woman?

Tarana: Absolutely. I think that socially weed smoking is a stigma because with it comes that assumption of hardcore drug use and image of a weed head who just sits on the couch, play video games, and eat pizza, not being a contribution to society... I think it's because I presented as that stereotype being black primarily. And then being a black woman, I think it's just expected almost which is sad... And that was another level of what made me feel so, I don't want to use the *h-word* and say hurt, but, feel not as valued and empathized by the nurse practitioner, is because my weed use, very, very honestly, was not at a limit where it needed to be managed... it was like, lady, do you realize there are users out here who are... doing way harder drugs?

I'm not hurting nobody, I'm not behind the wheel driving. I'm not out in the world wreaking havoc and being disruptive to society. Like, I'm being more of a contribution to society by smoking weed to stay indoors and be productive in my own space, than it would be to not be smoking weed being anxious as fuck and out in these streets feeling like shit and not being any type of helpful to society. But, you are trying to make me [re]consider my weed smoking based off of that? Is that what you're concerned about?

Deep within her story are themes of suspicion, dismissiveness, apathy, and bias. Although different than the other stories, Tarana characterizes her experience with the practitioner as mistreatment. She experienced a care provider neglecting to thoroughly read through and understand her medical history prior to starting the visit. She experienced a care provider ignore her bi-sexuality and center heteronormativity. She experienced a care provider question her use of cannabis to deal with her anxiety. Perhaps, the provider asked Tarana to explain herself out of her own curiosity – engaging in a clinician-patient relationship and seeking to further acquaint herself with her new case; nevertheless, Tarana received an uninvited white gaze forcing her to justify her actions.

Despite any possible intent of the practitioner's actions, their impact left Tarana feeling mistreated. Matthew posits, "When patients perceive or experience discrimination arising from implicit biases, they respond rationally by seeking to minimize the recurrence of the offense."¹⁵⁵ Patients will switch providers, not adhere to medical advice, and distrust their providers.¹⁵⁶

¹⁵⁵ Matthew, *Just Medicine*, Kindle location 116.

¹⁵⁶ Matthew, *Just Medicine*, Kindle location 116.

Tarana's perceived mistreatment left her feeling dismissed and avoidant of further medical treatment from Planned Parenthood. She entered into the care relationship hoping to gain insight on birth control options, disclosing her personal purpose for its use and her same-sex relationship. She left feeling her sexual identity was completely dismissed, while her racial identity caused judgment when she disclosed her use of cannabis. This story touches on the many intersections African American women navigate as patients in the healthcare system as well as their use of alternative therapies for wellness. With no access to medication or psychotherapy, Tarana used cannabis to support her mental health, a choice she has the agency and right to make for herself no matter the opinion of the healthcare community.

Patrice - "Am I Crazy?"

Patrice and I began our video call while she sat in her living room. We began our conversation catching up, sharing about how we are both coping during the pandemic, sharing in a collective experience of frustration, grief, and understanding. As we began to set collective boundaries around our interview, her mother-in-law passed behind her. "Hold on," she said. I waited as she walked to her bedroom, closed the door behind her, sat down, and sighed, "Okay." Patrice is a twenty-five-year-old newlywed living in San Diego with her husband, two-year-old son, and her in-laws – a prominent and well-known black family in the San Diego area. Patrice is an educator, a proud HBCU alumna, and her dedication to service within her community is as contagious as her smile.

When I first told Patrice about my research topic, she immediately declared that she had a story to tell. She sent me news articles and Instagram profiles of other young black healthcare professionals dedicated to tackling disparities within patient care encounters. Many of Patrice's resources focused on reproductive health and the national pandemic of black maternal mortality

– her story did too. Patrice’s definition of mistreatment was layered with personal experience and intentional reflection:

Mistreatment I think comes with the level of care in which a patient is handled... just the way a person is treated in terms of sensitivity, in terms of empathy, in terms of going above and beyond to make sure no stone is unturned. Making sure that they’re fully aware of their options no matter how long it may take. Whether it’s a language barrier or an intellectual barrier. Not feeling like you’re frustrated because, you know, something may not be making sense or this person maybe is not grasping the full extent. Or, if this is more serious, and they don’t understand they’re not taking it as serious because there’s maybe a level of misunderstanding... Where patients are not given the patience it takes to really inform them of their condition whether they’re taking it too serious or not serious enough... Not rushing to judgement because hey, they’re going through something that’s really tough and could be life threatening.

Patrice’s idea of mistreatment centers around empathy and patience. Providers who carelessly gloss over barriers to care and who refrain from investing time and concern into their patient care encounters, subsequently mistreat their patients with the potential to cause irreversible physical and psychological harm. For Patrice, providers practice mistreatment once they portray apathy, dismissiveness, impatience, and frustration toward those in their care. Patrice’s definition of mistreatment foreshadows her experience with a white paramedic called during a horrid moment in Patrice’s life:

About a year ago I had a miscarriage and it was very sudden and abrupt, because I wasn’t planning on getting pregnant either so that was a shocker. And then, to know, when I went for my ultrasound they just couldn’t find the heartbeat. So, it was a pregnancy that was really... I guess you can say underdeveloped. So, it wasn’t the most traumatic thing in the world where something happened and I lost the baby, it just wasn’t a developed pregnancy from the start... I was given a heads up in that, hey like you’ve been here twice, we can’t find [the heartbeat] so, you know, whatever. So, I think it kind of started in that process where when they were telling me this, kind of giving me that heads up conversation of what was going on and then what my options were. It was very, very dry. I mean, and I know that sometimes doctors have to be, and that might be a part of their training, but it wasn’t – I don’t think it was with the most empathy for – you know, that’s a huge deal. So, I think it could’ve been said with a tad bit more care about the whole situation. I think that’s the first thing that kind of rubbed me the wrong way. And, obviously, I was very upset after the conversation. Not solely because of... what was said but then also how the doctor delivered it I think was very dry and just, you know, whatever.

I think later on, I start going through the process. I have to call an ambulance to come pick me up from my home. The process is very similar to giving birth but you are expelling all of the content that is in you. So, it's very similar in terms of pain. It's very similar in terms of things are coming out and things like that. So, I had to call the ambulance and they came. I had three paramedics that were taking care of me. Maybe two. First guy was very nice, very sweet, talked to me with much care and was just really trying to get all the information, asking the questions, always checking in how I was doing. He was great. Now, the other gentleman, and this is where I think I experienced the most miscare [sic], and this was probably the worst part of the experience... We're in the ambulance and of course they have to ask you a lot of the same questions. Each person that comes up to you, pretty much asks you the same round of questions. I'm answering his questions, I'm trying to be as detailed as possible because I'm also nervous. I've never been through this experience. There was a lot of stuff that would scare the average person just in the bathroom. Just from what was happening.

So, I'm trying to explain to him, like, hey, I've been bleeding a lot and I've been told by the doctor that I need to call the ambulance to come get me if XYZ happens. And XYZ has happened so, that's why I called. Mind you, I'm also breathing like I'm having – [she makes the motion of a labored breathing process] it's the same process. So, very disheveled, very painful and everything like that. So, he is kind of, I guess, one, not the same level of care. What I am telling him, he's repeating back to someone else on the phone, but he's not repeating what I'm telling him... [that] made me feel like [he was] playing down my symptoms and really gave me the feeling like, *you didn't have to call us, you could've gone through this at home*, basically. Like, *we didn't have to come pick you up, you're making this bigger than what it is. You could've endured this in the privacy of your own home*. Which, a lot of women do. This is not something that you have to go to an emergency room, you can kind of wait it out. But again, my instructions that I was given, they told me, if these things happen, you need to go and go to the emergency room. If you can't be driven, you call the paramedics. And, I couldn't walk at that point. So, that was the reason for having them come out there. So, you know that just, I mean, and as you can see, that's the biggest part that I have held on to in this point. Because, I had to keep going back and telling him as he's relaying this information to the other medical staff... I'm saying, you know, "Yeah, there's quite a bit of blood." I'm giving him the details. But, what he's relaying is, "No, not very much bleeding. Minimal something." Like, if I said my pain level was on a scale of one to ten, a nine, he's on the phone telling them it's like a five... that's just an example, that's not verbatim.

Patrice shared her story with a strong fervor. Her passion flowed through every word she spoke.

Her story was surprising and angering. I wondered how a trained professional could disregard the words of someone sitting right in front of him. She described her story with so much detail I felt like I was riding in the ambulance with her, yearning to advocate for her by grabbing the paramedic's phone and telling them her truth.

She continued to share her story:

As he's relaying information to the person that's on the phone, I'm still on the other side, telling him, "No, that's not correct. That's not what I just told you." And, he [says,] "Oh, okay, okay." Then, gives me the feeling like, okay, well now am I crazy? Is there something that he knows better than I don't because, he's a medical professional? Maybe what I'm saying [is] translating to what he's giving. But, in my ears it's so different. I'm in *a lot* [her emphasis] of pain. There's *a lot* [her emphasis] of blood. And these are things that I think had something gone wrong, maybe, had I hemorrhaged or something, or lost too much blood, those are things that would've prevented the people at the hospital from knowing that – knowing the symptoms that I was already coming in with and things like that. So, that was something that definitely rubbed me the wrong way. And again, I haven't had a lot of hospital experiences. That was probably one of my first major ones where I wasn't going for a check-up or for something where I was supposed to be there. But, coming in as an emergency for myself. And, I felt that at that particular point, it was severely mishandled. And, I think even on a case by case basis, a miscarriage, that's something that's very sensitive, that's something that's very touchy. And, I think one of the paramedics kind of handled it that way, the other one didn't. Where it just, you know, I don't know, almost like it was something that was self-inflicted or something like that. Not that this is a horrible - you know...

The paramedic's blatant disregard for her words and subsequent gaslighting connoted a sense of suspicion and dismissiveness. The paramedic's condescending behavior signaled to Patrice that he questioned her request for emergency assistance; and, even in her storytelling, Patrice justified why she chose to call an ambulance at all. Matthew shares about her findings from interviews with minority female patients. She avers, "Several women reported that their narratives were discounted, disbelieved, or simply ignored by physicians who seemed committed to a stereotype of minority women patients. A commonly repeated narrative was the experience of being told 'you are fine' despite evidence of debilitating pain."¹⁵⁷ The paramedic downplayed Patrice's experience in a moment when her life hung in the balance. Patrice continued to advocate for herself, continued to speak her own truth and believe her own experience of deep pain and significant blood loss, urging the paramedic to believe her. She continues, "Even if it

¹⁵⁷ Matthew, *Just Medicine*, Kindle location 2155.

was a situation where my idea of a lot of blood is not the same as your idea of a lot of blood, there's a way that you could've done that without it deliberately going against and downplaying my concern for myself." Patrice grieved being ignored; she grieved her words falling upon impatient ears; she grieved not being believed in the midst of a terrifying experience, her body writhing in pain, unsure of what was to come.

Mental Healthcare and Support

Jemel - "I Just Knew She Would Believe Me"

Jemel and I had our interview in my home office. She arrived to my home looking forward to sharing her story and looking forward to speaking about one of worst experiences of her life. I previously engaged Jemel's story for an earlier academic project and I knew her experience spoke directly to the issue of mistreatment of African American women within the healthcare system. As we began collectively setting boundaries for our conversation, I asked Jemel what she hoped to accomplish during our interview. She replied, "Umm, to tell my story. I haven't really been able to talk publicly about what happened and so, that's I guess, the biggest thing for me is to be able to state what happened to be and have others know." Jemel wanted her story to be heard and I am grateful she chose to speak her story to me.

Jemel is a twenty-eight-year-old doctoral student pursuing her degree in ethics. Originally from Los Angeles, she currently resides in the Inland Empire in her family home. In addition to her studies, Jemel works with autistic youth, practices amateur photography, is in the ordination process of the Disciples of Christ denomination, and teaches herself how to roller skate. Jemel is a vegan, same-gender-loving, anime enthusiast with a passion for womanist theology, social justice and animal ethics. When asked to define mistreatment, Jemel avers, "I would say, *mistreatment* is treating someone as if they are not worthy of respect, not believing people,

misdiagnosing them. I would say, like, physical and mental harm. I think I already said respect, not being respectful, that's huge." Physical and mental harm become the result of disrespect and suspicion. Although mistreatment comes in many forms, the damage scars a woman's life in unfathomable ways.

Jemel's story begins following her diagnoses of major depression and bi-polar disorder. In the thick of her doctoral studies, Jemel lost insurance through her school, forcing her, like many other students, to enroll in Medi-Cal, California's Medicaid program. Because Medi-Cal dictates where she receives treatment, Jemel relied on the emergency services of a hospital in San Bernardino. What followed was graphic, upsetting, and unjust mistreatment:

I was diagnosed in 2017 I believe, October 2017, and from there things kind of went downhill. Eventually, I believe it was July of 2018 that I was feeling particularly low and depressed. And, so, that prompted me, or I guess my parents asked me, if I wanted to be checked into a facility, and at that point I agreed to go. To slow down. So, I voluntarily checked into a facility to be treated and the entire experience – I didn't fully know what I was signing up for when I went in. They told me that I would have to go into one particular room area to wait for a while until they were able to call me into the official space. So, they pretty much took me into the emergency psychiatric section of the hospital and not like their normal area. They did not tell me that the wait would take *days* [she laughs] ... When I walked into this space they told me take off all of my clothes, bra and underwear included, and I thought that was kind of odd but I didn't ask much of it because I thought I was going to go through a little physical before being admitted. And, so, they took my clothes and gave me this paper thin, see-through clothing, I guess, to wear, and told me to sit and wait and that's what I did. By maybe hour six of sitting in the same place and being behind a red line, and watching people walk up and down, some guy had a like this major outburst where he was, you know, beating down the walls and they had to have maybe five people on him to get him down, and that scared me.

I didn't realize is that because I was in the emergency area that a lot of people were just fresh out of prison and you know, they were coming off of the streets with a lot of things. And so, I was kind of in this environment where I started to recognize, like, okay, maybe this isn't the safest for me because... there are no proctors telling people don't talk to her or touch her or harm her. There are nurses and security that are worried about themselves. So, at that point, I wanted to talk to a nurse and I told them that I'm ready to go home. [Sarcastically] In other news, I'm okay! I'm ready to go! [laughing]. At which point they told me they would talk to the doctor, still making it seem as if I came in voluntarily, you know, they made it seem like it was okay.

In the first few hours of her visit, Jemel, a full-figured woman, was stripped of her clothing, donned a shear gown, and required to sit and wait for hours in a room with strangers. Feeling unsafe and vulnerable in the hospital's psychiatric emergency department, HT relied on the staff to mitigate any potential harm.

I remember meeting the doctor, I shook her hand [and said,] “Hi, I’m Jemel,” and I told her I was shaking because I was afraid at that point. I just didn’t know how to talk to this person who had this power and authority over me, apparently, to determine whether or not I could go home or not... We were in a private room and after I shook her hand and told her my name and why I was here she asked if we could go into the public space. So, we went to the public space, at which point, she tells me to stay behind the red line. At this point, I realized she’s afraid of me and the security guards are coming up. I’m talking to her and I’m saying – I don’t know exactly what I said, but I know I expressed like, I’m ready to go home. And she’s telling me no. So, I’m asking why because I know my patient rights, which you know, I can go home even if it’s against the advice of the physician. I’ll just have to sign paperwork saying that. I’m asking her why can’t I go home, and she’s not answering me, she doesn’t say, *oh because you seem this way or you seem that way or anything*, she just said, “Stop asking,” to the point where she said, “If you ask me again, I’m going to 5150 you.” Which we know means that I wouldn’t be able to go home – it’s no longer voluntary. Pretty much, that shut me up because she threatened me with a 5150 and I want to go home. In the process of doing this, it’s been a long day. The nurses are telling me that I show “failure to thrive” because I didn’t eat that day. And because I hadn’t taken a shower that day. And, I came in right after they had showers. I didn’t even know people were taking showers – I did not know the process of how this worked. And, I hadn’t eaten, but again... the food wasn’t vegan.

The 5150 Hold is a California state legal policy developed in the 1960s involving detaining a “mentally disordered person” for at least seventy-two hours when that person is assessed by a mental health professional to be of risk to themselves or to others.¹⁵⁸ Despite walking into the hospital voluntarily, the staff threatened Jemel with the law, using the law as a weapon to quiet Jemel from asking questions about her care. Furthermore, the staff labeled Jemel with “failure to

¹⁵⁸ “California Law,” California Legislative Information, accessed March 1, 2019, https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=5150.

thrive” because she refused to eat non-vegan meals. Jemel found herself growing deeper and deeper into the despair of her experience.

They made me stay in the emergency area. I ended up having to sleep there that night. With a roommate of mine... who had an outburst in the middle of the night while we were sleeping. People had to come in the room and take care of her and she’s screaming at them and they’re screaming at her. They’re not being respectful toward her at all... Like, listening to them is awful... This other woman who was in there, she was a black woman... they had derogatory things to say about her and the way she was behaving. And, I’m just like, you’re supposed to be my nurse! You’re supposed to understand *these* things, if anything. Like, why are you talking about patients this way? That was day and night one.

Jemel observed staff directly violating the sanctity of their care. With derogatory actions and comments, screaming at patients in clear duress, and perhaps performing deeply held biases about their patient population, the staff demonstrated overt disrespect and disregard for their patients – and Jemel witnessed it all on her first night in a space she sought for safe and comprehensive treatment.

The next day they’re telling me I have to wait to go to the next area... I had one doctor, he was a resident, and he was like, “Yeah, you seem fine. You should be able to go home today.” But, again, that didn’t happen. They made me stay. They finally got onto me being vegan. But they forgot every meal, and so, I would have to wait or I would have to talk to someone and say, hey I’m vegan I need an extra meal, a special meal, or something like that. So, food was difficult.

The gown, I think I mentioned, when I woke up the next morning it was so thin that it had torn. So, I had to wrap my blanket around me. I’m in this space, men and women, and like, I’m naked, so what am I supposed to do. So, I had to wrap a blanket around me and wait until its shower time to get new clothes. So, that was maybe about an hour or two. And, so I’m walking around with a blanket wrapped around me like a three-year-old, I don’t know... It wasn’t until that night that they came to take me to the regular area and being there wasn’t much better. I had to wait until day three to get clothes.

Jemel’s description of her treatment points to a wider issue of neglect. She entered the space as a vegan and informed staff of her dietary restrictions yet they rarely accommodated. She entered the space as a full-figured woman valuing her own body while valuing modesty yet was provided a one-size-fits-all gown that tore just by movement in her sleep. It took hours for her

gown to be replaced forcing Jemel to wrap her body in a blanket less she be subject to the gaze of others. Understandably, in the midst of her violation and neglect – in the midst of her mistreatment – Jemel wanted to leave. As a trained ethicist, Jemel knew her treatment was far from ethical, and during her hospitalization, she simultaneously worked to process the mistreatment of her humanity while attempting to seek treatment for her mental illness:

I'm reading my rights on the wall because they're on the wall. And I'm just like, I just want to get out of here and I swear I have the right not to be here because I asked them again if I can get out and they're like no, you have to stay another day. But, I came in voluntarily, so why can't I leave? That was the question. I came in voluntarily. I had no court order to be here, it wasn't a 5150, didn't get arrested. I walked in because I was feeling a certain kind of way and y'all [sic] are making me feel worse. I didn't see a therapist at any point while I was there. I'm kind of in this traumatic situation where I came in for my own mental health and I'm watching other people around me with their mental health issues and also feeling kind of threatened and afraid.

I have these ex-convicts, multiple men hitting on me and asking for my number and telling me things like I wonder what her nipples look like, and just having these types of conversations with them while I'm sitting next to them naked. And asking for my number. I had about three guys ask me for my number. One guy asked me for my number four different times in front of the nurses and the proctors. Why aren't you stopping them from asking for my phone number and from trying to hit on me and talk to me in this manner? That was highly uncomfortable to experience watching them watch me experience this. And not step in to help. And still, I'm naked. Because even though I'm in the "regular area," you guys are taking your sweet time to get me my clothes. So, day two goes and that happens.

Subject to both sexist and voyeuristic gazes, Jemel experienced severe harassment within the space she hoped would facilitate healing. Men she could not escape sexually harassed her with no consequences. The staff became complicit bystanders in Jemel's treatment, leaving her to defend herself in an already disadvantaged position. Her literal nakedness worsened her already profound vulnerability as a young queer black woman seeking mental health treatment with state-funded insurance. Jemel's body, her rights, her basic humanity were violated as she simply sat on the common room's couch, waiting to finally go home. Unfortunately, her mistreatment does not stop there:

Day three comes by. I wake up, I take my shower, I ask for my clothes again. They said they'll give them to me. Breakfast happens. Another activity happens. Then, finally they give me my clothes but they have to cut the wiring out of my bra and all these things... And day three I guess was okay... I'm used to it by now... I kind of started to get it together within myself like this is torture but okay. At which point, one of the nurses comes to tell me that I had hepatitis B. And this is after I told her I never used needle drugs, I never had sex, never any of these things.

I don't know exactly what hep B is. So, I said, "What is it?" and she said, "It's a disease," and turned around and walked away. And I went into my room and cried. Because I just found out that apparently, I have some illness that makes no sense. It's like inconsistent with my lifestyle. And I ask you what it is because I'm trying to figure out how I could have contracted it, did I get it while I was here? Like what the fuck happened? Because I know – as far as I know about hep B, there's no way I can have it. And you tell me it's a disease and turn around and walk away from me as if I'm nobody or nothing like I don't get that. Eventually they set it up where I could go home and my parents came to pick me up and I left there having experienced all that trauma and thinking that I had hep B. So, it's not like I felt any better going home because I'm like, wow I have this, I don't know, could be super horrible disease, life threatening. No information about it at all whatsoever. So, I'm doing my google searching and all of that. Long story short, I went home and there was a lot of tears. Because there's the feeling of being violated by the nurses, being violated by the doctor, being violated by the security officers, and everyone who didn't step in when I was dealing with people who were inside with me. And, just having to had stay there for three days as if it were a 5150 even though I came here voluntarily I still don't understand how they were able to legally hold me. So, yeah, that's my story.

Jessica: The hepatitis B, is that a factor?

Jemel: No, so that's another thing. I went to the doctor and I don't have hep B! So, that's part of that misdiagnoses part... I went months before I was able to get to the doctor. I went months thinking this and what the fuck does this mean and how am I supposed to live and dah di dah di dah [sic]. Before I found out the truth. So, just that much...the only thing that gave me a little bit of peace is that my roommate kept asking her people if she had hep B. Like, all of the time. She's like do I have hepatis, do I have hep B? That's something else like you gave her my diagnosis! So now she thinks she doesn't have hep B. How deeply did that screw her? I'm hoping and praying that she went somewhere to find out the right information. Because how do you mix up our paperwork? That's the only thing that could've happened.

The nurse bluntly and apathetically shared with Jemel the diagnosis of hepatitis B and subsequently chose not to answer any of her questions, quell any of her concerns, and sent her home worried about an illness she knew nothing about. Jemel sought out a second opinion only to learn she was given a diagnosis which she never had. Perhaps the nurse's error was due to faulty communication within healthcare facility structures, or, perhaps, stressful nursing

demands result in not taking the time to learn Jemel's name. Or, maybe, poor management and low employee standards make it commonplace for staff to avoid thoroughly reading patient charts and double-checking clinical documentation. Whatever the case, Jemel was given the wrong diagnosis, was provided no health or treatment education, and was then sent home forced to seek answers on her own.

As she sat across from me on the couch in my home office, I could not help but picture Jemel sitting on the couch in the facility's common area, wrapped in a blanket, hoping to create a barrier between herself and the objectifying gazes of those around her. I could not help but picture her alone, navigating a system in which she hoped would provide her with psychological support, but yet finding it only to betray her, violate her, and in turn impart significant harm and mistreatment. As Jemel tells of the psychiatrist being fearful of her for no reason of all, we lift up Loretta Ross who declares, "Being black is both a criminal act and an existential risk. The simple existence of blackness is a white trigger for rage, guilt, and fear."¹⁵⁹ Jemel felt treated like a criminal, she felt, at times, that her life was at risk. In her quest to manage her severe depression and to find resources to cope with her suicidal ideation, Jemel relied on a behavioral healthcare system that her and her family assumed was equipped to assist her, but instead proved that mental illness management for African American women is a much more challenging feat.

Meena - "I Didn't Feel Comfortable Going Back"

For centuries, African American women learned to use alternative, subversive, and controversial therapies due to the lack of safety and accessibility of the American healthcare system. The system's narrative of experimentation, eugenics, and cultural insensitivity push black women toward finding their own mechanisms and spaces for healing that align with their

¹⁵⁹ Ross, "Trust Black Women," Kindle location 1021.

values, spirituality, and goals of care. For days, teams of physicians did not treat Tamika's chest pain and the pain that arose with each struggling breath became too unbearable. Tamika left the hospital for a chiropractor, who after just forty-five minutes eased her breathing. For Tarana, cannabis serves as a way for her to find relief from her PTSD as she navigates the maze of state funded health insurance and goes months without medication. Although still deemed unconventional as a mental health treatment within many modern medical and psychiatric circles, cannabis helps Tarana manage her anxiety as an alternative to expensive pharmaceuticals. Much like chiropractors and cannabis, yoga, reiki, acupuncture, meditation, and other holistic practices grew as attractive alternatives to the hazardous healthcare system. Yet, despite black women's interest in more holistic based approaches to their wellness, alternative wellness practices often mirror the wider healthcare system in terms of accessibility, hospitality, and general treatment of African American women.

Meena hoped to shed light on this issue. A twenty-nine-year-old wife and dog mom, Meena balances fierce loyalty and fiery compassion with softness and warmth. Meena wears many hats: social worker, wife, dog mom, friend and recently added yoga instructor and reiki master to her repertoire. In her struggle with depression, Meena found that practices such as reiki, yoga, and mindfulness proved far more effective than other mental health treatments. When I recruited her for this interview, she hoped to specifically discuss this subculture of the American healthcare system that often presents as an open, welcoming, and holistic alternative to the sterile, scientific, and business-oriented image of modern medicine. Although she is now finding her way in the worlds of yoga and reiki, Meena's initial experiences with holistic healthcare were not always easy as a black woman.

As we joined our video call, the sun shone brightly behind Meena who sat comfortably in her San Diego home to tell her story. After checking in, sharing a laugh, and setting our intention for the interview, we dove right into Meena's story. Meena defines mistreatment as "lack of respect. And I think that when you respect someone you give them the benefit of the doubt... For me, mistreatment is just lack of respect in general. And lack of value." Unlike the stories of the other women, Meena's story centers holistic care. For our interview, she tells of her first experience with reiki:

This is more in regards to holistic health, in which I categorize as like yoga, reiki, and that kind of thing. Because those are things that I feel have helped me the most, more so than therapy or anything else. And, that's just my personal journey. But, I will share that for years I wanted to try yoga, and I just didn't feel comfortable because when I did go to a yoga studio I was often times the only person of – I won't say the only person of color – but I will say, probably one of the only African American people there. And I did not feel welcome, and I did feel out of place. There's also the first time I tried reiki. [It was at] a really cute place, it's called [name omitted], and it's in like, Mission Hills or something. And I just walked in and I didn't – all the staff was white. Which is fine, but they just weren't friendly and looked at me as if I wasn't supposed to be there. The reiki was great, like, the practitioner was great and everything but as far as the staff was concerned, they weren't friendly and I just didn't feel invited or feel like I belonged there. It was something where I would have gone back, but because I felt so uncomfortable, I didn't. And the reiki did actually really help me so I sought out different sources to get that.

We began to speak about cultural competency education within these spaces as a way for holistic health practitioners and their staff to begin valuing care seekers, like Meena, who do not often fit the stereotyped image of holistic health consumers. Meena notes the cost of services such as reiki or yoga studio membership as a significant barrier many African American women face when seeking alternative care. Consequently, these services market toward – and value – white women as their primary consumers. She expands:

I feel like they gave different treatment to people who they felt like would be ongoing customers and because the services are expensive, there's the assumption that maybe I wasn't going to come back, or something like that. That was just my opinion. I think that ties into education. Like, them making those assumptions. Like, as far as who would be

able to afford, or who their target customer is, I guess. I feel like that ties into education. 'Cause they're targeting a certain demographic and I didn't fit into that demographic.

When I went for the reiki appointment I was sitting and I was waiting for a little bit and I saw different people and I saw how they were greeted with a smile. Then I tried to smile at the same person who had offered a smile to several other people and they just stared at me. Or, like I mistakenly walked into a room because the rooms weren't labeled at all and like, this woman just stared at me and slammed the door in my face, like just little things like that. And also, the way I was spoken to. It was at first friendly, and then because I was giving my card number and I read it wrong, then the person who was charging me completely had a different tone... So, then afterwards, after I got the reiki treatment and stuff, I did want to look around their merchandise, but I just got the vibe that they thought I was going to, like, take something, so, then I just left... I didn't pay any less than anyone else. So, to not be greeted, or smiled at, or whatever, in the same way that other people were, to me is that - it's different treatment than the other customers. And that I wasn't valued enough because they didn't care, or maybe they didn't think that I would come back. And, I didn't because - it was kind of almost like a self-fulfilling prophecy.

Meena shared her story with anger and frustration coating the words she spoke. She lamented that the reiki studio she visited boasted about centering the guiding principal of *namaste*, yet chose to treat Meena as an outsider, unwelcomed, untrusted, and undervalued. Meena claims multiple times in her storytelling that she would have gone back to the reiki practitioner as she found significant benefit in the treatment, however, the rude and uncompassionate treatment she received by the practitioner's support staff convinced her otherwise. Meena encountered a deeply penetrating white gaze that prompted her to leave the studio and to not return. Her inability to return to the reiki practitioner impacted her recovery from depression, but, she knew she could not tolerate, nor did she deserve, their treatment. She continues:

When I did go in, I was out of desperation, like that's why I tried the reiki because I had been in such a depression for a long time. And, I think mental health is really important. When I personally, because I'm prone to getting depression, and I'm prone to getting depressed, it does affect my physical health and like last year I was getting sick a lot because I was depressed most of the year. So, I had gotten the reiki and I really liked the practitioner, like, she was awesome. She didn't treat me any differently than anyone else. Or, she treated me like a normal person, I guess if that makes sense. And I wanted to, I would've gone back to her and she suggested for me to follow-up in a couple weeks and I

would have but I didn't because I didn't feel comfortable going back to that studio or to that facility. It took me a little bit longer to recover. I ended up doing a reiki attunement with one of the girls that I do yoga with, which helped me but that was a couple months later. So, I think it just took me a lot longer to recover out of my depression and anxiety because I didn't follow-up with something that actually helped me.

Meena's story bears a cautionary tone for African American women seeking alternatives to the modern American healthcare system. Meena pursued reiki to manage anxiety and depression – choosing, like Tarana, to find holistic methods for mental healthcare rather than pharmaceutical medication. And, for both of them, it worked. Tarana and Meena found tools to care for their anxiety, depression, and PTSD that met their goals of care, aligned with their values, and allowed them to break their dependency on the healthcare system. Yet, both faced suspicion, apathy, bias, and stereotyping. Matthew suggests the biases and stereotypes held by healthcare workers outside of doctors have not often been studied. She is certain, however, “even medical staff workers such as receptionists... are also likely unconscious contributors to health disparities.”¹⁶⁰ Meena hoped to resist utilizing the American healthcare system and rely fully on holistic practices, but her treatment as she sought these practices left her still tumbling in the cycle of her depression and anxiety. Her story beckons the question: If African American are mistreated in both hospital rooms and yoga studios, *where are black women supposed to turn for care?*

Summary and Next Steps

Alicia, Stacey, Tamika, Opal, Patrice, Jemel, and Meena each shared their living human narratives to tell their stories of mistreatment. Our interviews turned into *boundaried* storytelling spaces filled with emotional, sometimes graphic, and sometimes heartbreaking stories. Despite

¹⁶⁰ Matthew, *Just Medicine*, Kindle location 758.

six interviews occurring virtually and during an unprecedented pandemic, the women and I still managed to come together to produce this knowledge of African American women's experience in healthcare. This experience of gendered and racial bias in the healthcare setting does not begin with these women's stories. They unfortunately add to a much longer narrative of mistreatment stemming from Anarcha's pain. I believe the present-day cause of this mistreatment is cultural transference and cultural countertransference at work within the clinical encounter – allowing generational trauma and implicit biases and cultural social locations to radically inform the care provided and received.

To interpret these living human narratives, I think with both cultural transference and cultural countertransference in the following chapter. Cultural transference refers to the person subconsciously holding knowledge of the history of mistreatment among black women, her past personal experiences of mistreatment, and her present embodied experience all within the clinical encounter. It takes seriously the collective memory of mistreatment among African Americans in all American systems and the role that memory plays in the behaviors of African American women patients and their perceptions of clinicians. Cultural countertransference is permanent and subconscious cultural positionalities, values, and assumptions that inform caregiving relationships. Cultural transference-countertransference as a hermeneutic explores African American women's collective memory of mistreatment in the healthcare system and explores clinician's perception of African American women based on their own cultural locations. Employing this hermeneutic to the living human narratives situates the women's stories in the grand narrative of mistreatment as it helps identify that even subconsciously, deeply historic and sociocultural trauma continues to be invoked in patient-clinician relationships.

CHAPTER 5
INTERPRETING LIVING HUMAN NARRATIVES:
HERMENEUTIC OF CULTURE

Thinking with a Hermeneutic of Culture

African American women's mistreatment is rooted in evils of white supremacy and patriarchy that infect all American systems. American healthcare mirrors broader American culture steeped in white supremacy, patriarchy, and racial inequality thus leading physicians and other clinicians to enact those same values and beliefs.¹⁶¹ These values and beliefs are morphed and molded into assumptions of African American women. Healthcare providers' cultural leanings integrally impact the clinical care encounter through the process of cultural countertransference. All the while, African American women carry their own cultural leanings with them into the clinical care encounter. They carry with them knowledge of collective mistreatment and awareness of how race and gender impact this narrative. They carry with them their own personal experiences of mistreatment, experiences of care that left them hurting and suspicious. They also carry that which caused them to seek medical treatment, whether that be pain, an emergency, pregnancy, or all three. I argue that the present cause of mistreatment within healthcare is cultural transference and cultural countertransference at work within the clinical

¹⁶¹ Washington, *Medical Apartheid*, 9.

encounter – allowing generational trauma, implicit biases, and cultural social locations to radically inform the care provided and received.

To better understand the experience of mistreatment shared through the interviews, I developed a psychoanalytic hermeneutic to interpret the narratives. This hermeneutic approach addresses the research question: *what happens within the clinical care encounter that leaves African American women feeling mistreated?* Through thinking with a hermeneutic of cultural transference-countertransference, the cultural dynamics at play within the care encounter are revealed and positioned to be further explored for their contribution to mistreatment. This hermeneutic is intended for narrative inquiry and involves analyzing subconscious, culturally-rooted relational behavior of both the patient and the provider.

Cultural Transference

Sigmund Freud’s original concept of transference describes a natural occurrence within a caregiving dyad where the patient’s feelings and reactions toward their clinician are based on past experiences and relationships.¹⁶² I suggest cultural transference, then, describes the patient holding knowledge of the long history of mistreatment with African American women, her past personal experiences of mistreatment, and her present embodied experience all within the clinical encounter. Dayna Bowen Matthew posits, “When a patient meets a physician – even one of his or her own race – that patient brings a store of social knowledge about physicians generally and about the physician’s racial or ethnic group, specifically.”¹⁶³ She names this store of knowledge as the cause of African American patients’ distrust and avoidance the healthcare

¹⁶² Sigmund Freud, “An Outline of Psycho-Analysis,” *The International Journal of Psychoanalysis* 21 (1940): 53.

¹⁶³ Matthew, *Just Medicine*, Kindle location 1026.

system. I argue that this store of knowledge forms and shapes the cultural transference within the care encounter.

In her 2006 text, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*, medical historian Harriet Washington examines both the history of medical experimentation with African Americans and its contemporary legacy of iatrophobia, or mistrust of healthcare professionals and institutions.¹⁶⁴ Washington begins her exploration of iatrophobia by providing the social history of several large-scale cases of gross historical and contemporary medical research and experimentation on black bodies such as federally funded eugenics programs and the Tuskegee syphilis experiment. Washington argues that America's obsession with scientific experimentation of black bodies causes iatrophobia and continues to limit African American's full participation in the healthcare system.¹⁶⁵

A 2020 Kaiser Family Foundation (KFF) study exploring African Americans and their perception of racism in healthcare during the COVID-19 pandemic found that seven in ten African Americans believe they are treated unfairly based on race or ethnicity when they seek medical care and fifty-five percent of African Americans report that they do not trust our nation's healthcare system.¹⁶⁶ While African Americans as a whole experience collective mistreatment, the study found that African American women in particular express mistreatment more than men. The study found that within the past twelve months, twenty-five percent of African American women and thirty-seven percent of African American mothers felt they were

¹⁶⁴ Washington, *Medical Apartheid*, 20.

¹⁶⁵ Washington, *Medical Apartheid*, Epilogue.

¹⁶⁶ Liz Hamel et al., "Race, Health, and COVID-19: The Views and Experiences of Black Americans," (KFF, October 2020), 22-24.

treated unfairly based on race when seeking healthcare as compared to fifteen percent of African American men.¹⁶⁷ African American women reporting higher rates of mistreatment are not simply trends of racial and gendered bias and healthcare. These are violent and emotionally loaded experiences filed in the collective and individual stored knowledge of African American women lending itself to the perpetual cultural transference at play within clinical care encounters.

African American Women Patients' Stored Knowledge

Stored knowledge of mistreatment results in fear and mistrust of healthcare and shows up as cultural transference. The storytellers noted awareness of a collective history of mistreatment, noted past personal experiences of mistreatment, and noted embodied experiences of mistreatment within the storied care encounter.

Awareness of the Legacy of Mistreatment

I first identified cultural transference in a living human narrative through identifying the storyteller's awareness of the history of mistreatment among African American women. This awareness includes awareness of racism and sexism that contributes to bias and prejudice toward African Americans. African American women's engagement in healthcare is informed by this collective awareness of unfair treatment and communal iatrophobia. I believe national events such as the syphilis experiment at Tuskegee, "Mississippi appendectomies," the HIV/AIDS epidemic, and the COVID-19 pandemic are gaping wounds felt by many African American women across generations and social locations. African American women carry this knowledge with them into the care encounter and this knowledge situates itself in the cultural transference occurring within the clinical space.

¹⁶⁷ Hamel et al., "Race, Health, and COVID-19," 26-27.

The women's definitions of mistreatment included a lack of respect, a lack of concern, and a lack of empathy. They described mistreatment as not being listened to and the possibility of physical and emotional harm. All of the women entered into our interview aware of the ways African American women have experienced mistreatment in the past. Their education levels, social locations, and interest in participating in the research study signaled their awareness of this unfortunate legacy. More so, their definitions of mistreatment signaled their knowledge that this is a phenomenon not only an individualized encounter. As they told their definitions of mistreatment, they spoke not only of their own encounters, but of the way they have come to understand mistreatment within the healthcare system throughout their lives.

Past Experiences of Mistreatment

A second method I used to identify cultural transference within the care encounter is through identifying the storyteller's expression of past personal experiences of mistreatment. As the storyteller names connection between the present clinical encounter and a past clinical encounter she signals that the past experience influences the perception of the present. The storyteller brings past encounters, harmful and helpful, with her into the care encounter and projects those experiences onto her current clinical care provider. Perhaps the providers are similar in ethnicity, age, gender, or occupation. Or, perhaps, the storyteller views clinical care providers as authoritative figures and generalize characteristics and behaviors. Nonetheless, exploring the influence of past experiences in the living human narrative illumines the work of cultural transference in the care encounter.

Almost each woman prefaced one story with the experience of another. Alicia talks about her years of attempting to find answers before finally being diagnosed with multiple sclerosis. She felt her symptoms were often overlooked and dismissed, and she carried that with her into

her storied care encounters. Stacey told the story about healthcare in her childhood before sharing about a care encounter as an adult. She noted the trend of “a new unfamiliar doctor” in her receipt of mistreatment. She brought her past encounter as a child into her storied clinical encounter as well. Tamika shared that throughout her medical journey, she felt regarded as a “research project.” Her consistent feeling of being observed and monitored perhaps contributed to how she describes her medical treatment today. Both Opal and Patrice spoke to initial encounters with physicians prior to the encounter they expand on in our interviews. They note how those initial encounters were the starting points to the mistreatment they received over the course of their pregnancies. The women took past experiences of care and projected them into the narrative of mistreatment, further allowing them to feel certain that their experience of care was subpar.

Embodied Experience of Mistreatment

The final method used to identify cultural transference is noting the women naming their embodied experiences of mistreatment during the care encounter. Embodied mistreatment is felt both cognitively and physically. The storytellers reported being dismissed, ignored, mistrusted, gaslighted, and criminalized during the clinical encounters they shared during our interviews. The women experience deeply violating and isolating feelings of mistreatment in addition to the embodied experiences of pain, discomfort, or depression that brought them to the care encounter in the first place. These experiences become embodied mistreatment because the storytellers report being ignored while screaming in excruciating pain and being dismissed while dragging their numb legs. Noting the storytellers’ expression of embodied experiences of mistreatment within the care encounter highlights cultural transference as it indicates the storyteller’s

awareness – conscious or preconscious – of her unfortunate participation in mistreatment. Each woman’s story tells of their embodied mistreatment.

Cultural Countertransference

With transference pertaining to the patient’s feelings and reactions toward the clinician, the concept of countertransference describes the reciprocal – the feelings and reactions of clinicians toward patients based on the clinician’s experiences and relationships. Like transference, countertransference naturally occurs within the caregiving relationship. Pamela Cooper-White describes countertransference as “the helper’s own subjective experience of coconstructed body of knowledge about both self and other, and about the shared relationship in which they mutually participate.”¹⁶⁸ I define cultural countertransference, therefore, as clinicians’ permanent and subconscious cultural positionalities, values, and assumptions about the careseeker that informs their caregiving relationships. Cultural positionalities include the provider’s racial-ethnic identity, gendered identity, occupational identity, and other markers positioning the provider in society. Cultural values are rooted in the providers’ education system, family system, religious system, national government and other systems of philosophical impact. Cultural assumptions are projections of providers’ values and biases onto those in their care. Each of these aspects of cultural countertransference has the potential to contribute to mistreatment for African American women care seekers.

In her 2015 text, *Just Medicine: A Cure for Racial Inequality in American Health Care*, Matthew conducts interviews with physicians across the United States to explore how discrimination in healthcare contributes to health disparities in racially-ethnic minority

¹⁶⁸ Pamela Cooper-White, *Shared Wisdom: Use of the Self in Pastoral Care and Counseling* (Minneapolis, MO: Fortress Press, 2004), Kindle Location 844.

communities. Matthew names the cause of discrimination to be unconscious racial and ethnic bias.¹⁶⁹ Many of the physicians Matthew interviewed entered the study unaware health disparities exist. Others who were aware of their existence asserted that their particular areas of medicine went unscathed by the perils of disparity. Many more could not fathom the possibility of them personally contributing to the health disparities of their patients.¹⁷⁰ As highly trained scientists, physicians often feel their education, objectivity, and rationality demonstrate their egalitarian values and shield them from bias.¹⁷¹ Admitting to biases would contradict their intention to provide ethical and quality care to their patients.¹⁷² Matthew argues that compared to other professions, healthcare professionals often enter into the healthcare field out of altruism and humanitarian motivations.¹⁷³ The majority of physicians interviewed within her study and otherwise, therefore, participate in the phenomenon of unconscious or implicit racial and ethnic bias. Implicit bias describes unconscious and negative attitudes held towards others in a different social group. American healthcare professionals are more likely to operate out of their deeply held subconscious attitudes and beliefs, rather than their expressed intentions and motivations and unconsciously enact those beliefs in their patient care.^{174,175}

Cultural countertransference contributes to mistreatment when implicit bias shows up in the care encounter. When contributing to mistreatment, cultural positionalities are rooted in power and privilege, cultural values are rooted in Americentrism, white supremacy, and patriarchy and cultural assumptions are rooted in stereotypes of African American women.

¹⁶⁹ Matthew, *Just Medicine*, Kindle location 95.

¹⁷⁰ Matthew, *Just Medicine*, Kindle location 672.

¹⁷¹ Matthew, *Just Medicine*, Kindle location 693.

¹⁷² Matthew, *Just Medicine*, Kindle location 777.

¹⁷³ Matthew, *Just Medicine*, Kindle location 693.

¹⁷⁴ Matthew, *Just Medicine*, Kindle location 758.

¹⁷⁵ Matthew, *Just Medicine*, Kindle location 777.

I do not have access to the care providers' lived experiences. I often asked the storytellers to describe the provider's race, gender, and age group, but of course, without the clinician self-identifying, knowing their race or gendered identity is not possible. In addition, I also have no access to the providers' educational background, religious affiliation, political affiliation, or any other philosophical identifiers of their cultural values and positionality. Therefore, I identify cultural countertransference within the care encounter through identifying socially constructed controlling images of African American women that emerge within the living human narrative.

Controlling Images of African American Women Patients

Through reading the narratives across a hermeneutic of cultural transference-countertransference, I argue that socially constructed controlling images of African American women in healthcare summarize the confluence of providers' cultural positionalities, values, and assumptions. Black feminist sociologist Patricia Hill Collins describes *socially constructed controlling images* as emerging from slavery and the Jim Crow era and perpetually engaged to control the perception of African American women in society.¹⁷⁶ These images run parallel to the African American women's mistreatment that spans across generations. Collins' controlling images include the mammy, a sexless sacrificial caregiver; the matriarch, an aggressive unfeminine woman with super strength; the welfare mother or welfare queen who takes advantage of systems and lacks the moral agency to care for her family; and the jezebel, a manipulative sexual aggressor. Because these images continue to pervade all American institutions and systems, the healthcare system inevitably adopts these conflicting, racist, and

¹⁷⁶ Collins, *Black Feminist Thought*, 72.

misogynist tropes. I appropriate each of these images into socially constructed images of African American women patients to better identify these images within the living human narratives.

The Welfare Mother or “Charity Case Patient”

The image of the welfare mother has been used for decades to justify reproductive control—labeling black women as unfit mothers. This image emerged as African Americans began to secure social equalities in education and housing. Seen as a threat to the white middle-class, the welfare mother proved that controlling the fertility of African American women would be of benefit to society.¹⁷⁷ The welfare mother is lazy, irresponsible, and a burden to the social welfare system. In the healthcare system, the welfare mother is a “frequent flier” who often visits the emergency department for her primary care. The untrustworthiness and irresponsibility of the welfare mother renders her unable to be believed when she tells her story or shares her symptoms. Some clinicians may assume she only rates her pain as a ten out of ten because she wants a prescription narcotic to sell on the street. The welfare mother image is a burden to the system, or a “charity case,” whose cost of medical care is absorbed by the hospital. The majority of public health initiatives, including reproductive health, target the welfare mother image because limiting her reliance on hospital systems drives down costs.

The Jezebel or “Human Subject Patient”

Jezebel’s image also justifies reproductive control and paints African American women’s sexual expression as promiscuous and sexually aggressive. This image was perceived to justify the use of enslaved African American women to mass produce children for their owner’s economic gain and to justify the sexual abuse of black women’s bodies particularly by white

¹⁷⁷ Collins, *Black Feminist Thought*, 79.

men.¹⁷⁸ Black women were not seen as fully human but were regarded solely for their reproductivity. The controlling image of jezebel haunts healthcare systems when African American women's bodies become an object used for the economic, scientific, or educational advancement of others. The jezebel image leaves women's bodies victim of medical experimentation or educational medical presentations. When new, unregulated birth control options are rolled out, jezebels are targeted to explore, or test, these new methods and their side effects. When medical students are learning how to perform innovative medical procedures, jezebels' bodies are gazed upon while lying unconscious on surgical tables. The jezebel image is not fully human which justifies her body being taken advantage of by clinicians and systems.

The Mammy or "Strong and Religious Patient"

The mammy image binds African American women to an image of perpetual motherhood and caregiving. She is a sacrificial, asexual, maternal figure who ignores her own needs to care devotedly for the white family she works for.¹⁷⁹ The mammy image has become the expected jovial and docile behavior of African American women. She is an image of piety, resilience, and strength. In the healthcare system, the mammy image takes on a perpetual caregiving role. CPE residents and interns share verbatims of older religious black women and report, *she is so strong and I learned so much from her*. Clinicians smile and pray with mammies, reminding them of their strength. The mammy image is a burden of strength that hushes African American women who want to scream in pain or cry out when facing mistreatment. Clinicians mistake her perceived religiosity for fearlessness and assume she can handle blunt conversations about terminal diagnoses and offer to call the chaplain after lives are shattered. The mammy is

¹⁷⁸ Collins, *Black Feminist Thought*, 79.

¹⁷⁹ Collins, *Black Feminist Thought*, 74

expected to pray through pain, push past discomfort, and to silently grieve changes in her health, as not to upset those around her. When black women's strength is not seen as pious and subdued, their behavior is labeled deviant and their independence becomes a threat.

The Matriarch or "Non-Compliant Patient"

The matriarch image has morphed into *the angry black woman* portrayed throughout media. In the healthcare system, the matriarch image is aggressive and non-compliant and perhaps seen as a threat to the safety of healthcare staff. When she declines a medication or questions a procedure, a security guard may be placed outside her door. The matriarch is assumed to have superhuman strength. When she shares her excruciating pain, clinicians roll their eyes, assuming it cannot be *that* bad if she walked into the emergency department by herself. The matriarch image is violently independent and over the course of her hospitalization she may find herself alone, with no one feeling the need to check on her throughout the day and night.

In certain ways, all of these images intersect and borrow from one another. Multiple controlling images are often prescribed to the same woman. The charity case patient, the human subject patient, the strong and religious patient, and the non-compliant patient, are all controlling images persistent throughout healthcare and emerge somehow within the living human narratives. These images leave African American women perceived as untrustworthy, deviant, irresponsible, independent, and inhuman. Although these images emerged in slavery and Jim Crow, their legacies apply to the stereotypes of African American women that appear throughout healthcare today. When clinicians adopt these controlling images of their African American women patients and attribute truths to their constructed narratives they run the risk of justifying and participating in mistreatment.

Summary and Next Steps

Cultural transference-countertransference as a hermeneutic for living human narratives explores the patient's cultural transference by identifying her awareness of the history of mistreatment, identifying her personal previous experiences of mistreatment, and identifying her embodied experiences of mistreatment. This hermeneutic explores clinicians' cultural countertransference by identifying controlling images of African American women that emerge within the care encounter. Cultural transference-countertransference takes seriously the collective and intergenerational terror and trauma caused by a healthcare system that horrifically abused black bodies quite literally since its inception. It also takes seriously the ways the healthcare system continues to perpetuate and justify its control and mistreatment of African American women's bodies in particular.

While a hermeneutic of cultural transference-countertransference explores narratives of mistreatment, a hermeneutic of psychospirituality explores narratives of meaning making. Narratives of meaning making tell of how Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena worked with their experiences to critique and reimagine the healthcare system where cultural transference and cultural countertransference resist causing mistreatment. The following chapter provides eight living human narratives of meaning making.

CHAPTER 6

LISTENING TO LIVING HUMAN NARRATIVES:
NARRATIVES OF MEANING MAKING

Narratives of Meaning Making

Following hearing each woman's story of mistreatment, my research partners and I turned to understand how meaning was made out of each experience. I define meaning making as actively and introspectively working with an experience and engaging that experience through lenses of spirituality in order to heal, move forward, learn from the experience, and apply those learnings to life. African American women's traditional use of spirituality to cope and make meaning out of negative experience grounded this section of the interview process. While traditional clinical pastoral theological paradigms privilege the theological investigator as the one who facilitates a meaning making process amongst storytellers, this womanist clinical pastoral theology situates meaning making as the sole task of the storyteller. My role was to collect narratives of meaning making by facilitating a space where the women could spiritually and imaginatively speak to how they made it through the wilderness of healthcare. It was in this collection of meaning making narratives that I began to witness how the standpoint of African American women mistreated by the healthcare system could best provide perspective on the critique and reimagination of the system.

This chapter tells the living human narratives of meaning making of Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena in order from chronic illness diagnosis and management, reproductive and maternal healthcare, and mental health support. The narratives

flow from reclaiming difficult experiences to naming how to transform the healthcare system for black women for generations to come.

Chronic Illness

Alicia - “I Know My Body Better Than They Do”

Alicia reflects on her experiences of dismissiveness, bias, and apathy in the healthcare system with a sense of wisdom and resolve. Her sixteen-year journey with multiple sclerosis and navigating a faulty healthcare system as a chronically-ill patient left Alicia with much opportunity to process her experiences, cultivate self-awareness, and develop the capacity to articulate how she prefers to be treated as an African American woman patient. Our interview shifted focus from the stories of mistreatment to exploring the meaning making process of African American women as they carry their painful experiences of mistreatment with them on their journeys toward health and wellness. Shifting the focus from the narrative of mistreatment to the meaning making process uncovers theological implications around the treatment and subsequent emotional, spiritual, and psychological harm manifested by their experiences. Exploring the meaning making process, or inner-world, of African American women with common experiences within a similar geographic area, illustrate subcultural particularities for Southern Californian African American women and how they understand, process, and reframe their experiences of mistreatment. Most importantly, such exploration points to not only how African American women understand their experiences of mistreatment, but how they prefer to be treated as patients moving forward.

I facilitated the shift within Alicia's interview by inquiring, "How would you want to be treated as a patient in the American healthcare system? If you could go back to those stories that you shared, how would you have wanted to be treated?" After a pensive sigh, she responds:

I would like to have felt heard. When I told the doctor that I was having numbness or tingling or whatever the symptom was, that they listened. That, *okay, let's explore that*, rather than, *well, you can't see numbness, and you can't see tingling, so, it must not be there*. That was the attitude. So, I would like to have been treated as though I know my body better than anybody else. So, respected in that way. I have no reason to make up symptoms. And, with the cost of doctor's visits and everything else, even with insurance, you don't go to the doctor just to be going. You know? And, if they had respected even the way that I walked in there, dragging my foot and things they should have seen that this was not in my head. So, again, I would have liked to be treated with respect that I knew what I was talking about.

Alicia laments clinicians unable to honor her awareness of her own body and dismissing her complaints of numbness and tingling. Alicia felt her voice, her experiences, and her self-knowledge were irrelevant while she sought treatment for a life-altering illness. But, she mindfully reclaims her sense of self-awareness and self-worth as a patient, declaring herself worthy of both the respect and trust of her care providers.

Alicia seeks the trust of her care providers hoping they believe that she is experiencing abnormal symptoms. Even as she dragged her leg into her medical appointment, she was still met by a suspicious gaze as her physician wondered if she made up her symptoms. Even as the paramedics carried her from her bedroom as she fought through the deleterious side-effects of her medication, she was still met with a suspicious gaze as her paramedics wondered if she suffered from drug addiction. While Alicia defined mistreatment as care providers refraining from valuing the information shared by their patients, she describes her own experience of mistreatment not only as a lack of valuing her information or self-knowledge, but not trusting

and believing that self-knowledge as well. A lack of trust becomes the primary lens through which Alicia understands her own experiences of mistreatment within the healthcare system.

While distrust and the dismissiveness of voice begins to form the foundation of Alicia's experiences of mistreatment, tenants of gratitude, trust, and voice shape the spiritual lens from which she makes meaning out of those experiences. In words directed to the divine she utters, "I am sorry that I have had this experience but I am grateful that I have had this experience. And, I am truly grateful that the illness is not worse than it is. And, that in this I have found a stronger faith, and I have found a voice so thank you, God, for allowing me to be an advocate." As Alicia intersects her experience of mistreatment with her spirituality she expresses gratitude; for where there was a dismissal of her voice in the midst of her mistreatment, she found her voice in her meaning making process; where a lack of trust characterized her mistreatment, she found that God trusted her to be an advocate for other African Americans diagnosed and living with multiple sclerosis; where she found loneliness in her experience as an older black woman with multiple sclerosis, through her meaning making process, she found connection to others and a sense of legacy building that allows her to use this negative experience to positively impact the lives and healthcare of others.

Throughout the course of her diagnosis, Alicia became an integral member of the National Multiple Sclerosis Society (NMSS), working to lobby for disability rights at both the state and national levels. She hosts a plethora of fundraising events, becoming one of the top donors in her NMSS chapter in San Diego. And, most importantly, Alicia works to advocate for improved healthcare for herself and for other African Americans navigating multiple sclerosis and other disabilities. On her work she notes:

I have tried to speak up with my general practitioner and my neurologist so that they recognize that I know my body better than they do. And so, I think that I have rather it

goes anywhere beyond them, I think that I have built a relationship with them that they can see that this, ok, this older black woman knows what she knows. But, I also would like to think that speaking up and speaking out in various places for the MS Society, I am giving a face to other black women and men, which by the way, there are a substantial number of diagnoses, but I'm giving them that lift to speak up for themselves and to see that, or to hopefully see that okay, I can do this. She has MS and she's doing okay. So, hopefully, I can inspire and have inspired other people of color.

In the doctor's office, at the state capitol, and in her everyday life as a black woman navigating disabilities in an abled-body-centered world, Alicia works to educate care providers while advocating for herself and others like her. Through various processes of meaning making over her sixteen-year journey with multiple sclerosis, she recognizes that her clinical experiences are part of a much larger narrative of mistreatment in healthcare and finds education to be one of the main mediating factors. She chose to conclude our interview by sharing one last piece of wisdom, or rather, a call to action:

I think when you hear the stories about black women and the healthcare system, rather it's in relation to amputations from diabetes, or childbirth problems and those things, it proves that we still have such a long way to go. And, maybe one of the things that we should be teaching our pre-med students no matter what their field, is cultural competency. One of the things that I have always said after the ambulance incident was that I wanted to find a way to teach police officers, teach paramedics information about MS and people who have MS and what the symptoms are, and things of that nature. I never pursued that but that was always something that I felt was necessary... Education is extremely important.

In the African American storytelling tradition of call-and-response, Alicia's call to educate care providers around cultural competency and symptoms of multiple sclerosis warrants a response by those hearing or reading her story. Through processing her encounters not only within our interview, but over the course of her journey with chronic illness, Alicia finds education to be a clear way to impact change and to disrupt the possibility of further experiences similar to hers. A call to education across caregiving disciplines that centers diversity in culture, ability, and other differences becomes the legacy of Alicia's mistreatment.

Stacey - *“It Sticks with You”*

It seemed that Stacey’s meaning making journey was only just beginning. She had much to process around her experience in seventh grade and the lingering hurt the encounter caused. The physician’s assumptions and lack of empathy installed within Stacey a suspicion around health providers, evident in her story about her IBS. In asking Stacey how she would like to be treated given the opportunity to go back to either her seventh grade or adult experience, she affirms,

I think that seeing how doctors interact with my current children is probably how I would’ve wanted to be treated when I was young, in terms of just showing compassion, like, ‘Oh, I’m so sorry you’re feeling this way, you must feel really lousy, let’s try to figure out what’s going on with you,’ and not assuming from the beginning what kind of illness that I had; but, like, actually running tests and then telling me instead of just guessing. I think I would’ve liked to be treated like they understood that I was in pain and they wanted to help instead of trying to put blame on me for my condition.

Stacey draws parallels in her stories by claiming both physicians assumed or *guessed* her illness without proper examination and blamed her for her condition. Rather than assumptions and blame, Stacey prefers empathy and trust. She prefers her providers trust that she is in pain, empathize with her experience, and patiently provide appropriate care.

As we further processed her stories of mistreatment, Stacey seemed to be grieving her experiences. By sharing her story, she began to hear it, frame it, and process it from new spaces. Her tone expressed righteous anger and empowered frustration. It’s as if she suddenly awoke to what happened to her as an injustice and she grew angry. I asked how she places God into the complexities of her stories and she had some trouble articulating a response. Finally, she says,

I mean, I don’t think that God would have treated or does treat people the way that those medical providers kind of brushed me off and made assumptions. Because, I mean, we know that in the bible, Jesus sat down with sinners and people with various illnesses and didn’t judge or blame. And healed without question. So, I certainly think that their actions weren’t Christian like... I know God to be a comforter, so, I think just acknowledging what I was experiencing. Yeah, I think that’s probably the biggest thing is

just acknowledging. Like, even now I think that's a big part of comforting someone, is just acknowledging what they're going through and letting them know that it's real so that they don't feel completely alone.

Stacey compares the behavior of her medical providers with divine qualities of comfort, empathy, and unconditional support. She notes the clinicians' judgements and assumptions about her juxtapose Jesus' actions of sitting with those in marginalized positions. Her image of God as a comforter left her searching for similar qualities of support and acknowledgement by those providing her care.

Her spirituality offers direction to justify her frustration and lament towards the clinicians. Her theology calls for care providers to provide comforting and empathic support, and by not living into her expectation, Stacy grew disappointed in her treatment. I concluded each interview by asking the women how they hoped their stories improves the treatment of African American women in the American healthcare system. I hoped to grasp the legacy *they* hoped to leave by telling and processing their stories of mistreatment. Legacies that most certainly leave wisdom and insight for systemic change:

Jessica: How do you hope that telling your story transforms or improves the ways that African American women are treated in the healthcare system?

Stacey: I hope that it is enlightening for folks that even young girls who are in seventh grade and never kissed a boy have to deal with the biases of professionals - people who are supposed to be professionals. And, so it starts young. It's not just older black women and that it sticks with you. It impacts your life and your future choices. I think that people in the healthcare setting really need to think about their words and how impactful they can be especially to people at such a young age.

The actions of care providers like Stacey's leave a legacy of pain in the patient as well. Stacey calls for providers to consider how their words and actions, particularly those soaked in prejudice, impact patients at every age. Stacey's call for awareness is based in the hope that if providers recognize the lasting harm of their mistreatment, they would aim to consistently

provide more empathic care. This empathic care would mitigate women like Stacey from carrying shame and anger for decades following a doctor visit.

Tamika - “I’m a Whole Person Here”

Tamika’s consistent utilization of the healthcare system unfortunately afforded her plenty of opportunity to experience poor care. To better understand how she processes and makes meaning out of these experiences, I continued to focus on her story of the physician who called her a liar:

Jessica: When you went in for breathing issues, imagine going back, you present to the emergency department, and you explain what you’re going through. How would you have wanted to be treated?

Tamika: I would’ve appreciated a doctor that wasn’t drugged up, first of all. Like that felt completely out of line, completely out of order that no one can visibly see this lady is doing these things with her face? That is not right. Second of all, I think, sometimes I think they could’ve moved me into a room faster. Sometimes I think it was just laziness and slothfulness that would leave me in a hallway in the emergency room. Yeah, that night in particular, yeah, I think that’s it, they just move really slow sometimes. And, sometimes it felt like, yeah, no there’s not that much going on here.

Tamika notes the physician as “drugged up,” an accusation that of course, if true, would cost the physician much more than her career. A myriad of potential causes for the physician’s behavior of “licking her nose,” including disability, could be provided to refute or discount Tamika’s remarks. However, doing so would enact the same mistrust and dismissiveness Tamika believes characterize mistreatment. In the choice to trust Tamika and her physician’s description, we see she is calling into question the professional ethics of the practitioner. Her hope for adequate treatment simply begins with receiving a professionally ethical care provider. Tamika also reflects on the emptiness of the hospital and she recalls sitting in the hallway of the emergency room. She wonders if *slothfulness* caused them to not quickly move her into a room. Tamika wanted to be treated with urgency, which requires empathizing with the discomfort of waiting and waiting in a hallway.

As she reclaims her treatment narrative, she adds:

I wish someone could've paid attention to [my presenting condition]. After we've done all of these other testings and it's not *that*, what else could it be? What alternate thing could it be? Sometimes that's the issue. These doctors are so limited in their thinking that they don't open up a little bit to say, oh maybe this is what it is, or, maybe we need to bring in, you know, chiropractor upstairs, to take a look. So, I think I would've wanted a wider scope and a wider perspective in terms of what was coming up for me, and not just research, research, research this kidney! Pull all the blood! That's not what's happening here. Help me.

As she revolved in an out of hospitals and doctors' offices, Tamika felt their primary focus was on her kidney disease. Despite presenting to the hospital with breathing difficulty, the attending physician and her team wanted research Tamika's kidneys. Tamika, in turn, felt this was inappropriate as she describes physicians as often treating her like an experiment. She continues,

I mean, it was some sick race to figure it out, versus, hey, I'm a whole person here. You know, the dialysis is taking care of the kidney but some other stuff is coming up. Sometimes I think the doctors are just limited and a lot of them aren't tapped in or in tune, they're just kind of, its rote medicine, we just going to keep performing the same experiment.

By continually focusing on her kidney disease, Tamika felt like other ailments impacting her life were routinely ignored. Her whole person was rarely acknowledged due to an underlying medical condition she could not control. She sought treatment to help her breathe, not for her kidney disease.

In all of her frustrations and experiences of mistreatment throughout the course of her life and especially in the midst of her chronic illness, Tamika maintained a sense of spirituality that grounded her as she made meaning and processed her experiences in healthcare. Because of her chronic illness, the healthcare system was unavoidable, but through faith, Tamika found new strength to navigate the system that caused so much pain. She recalls, "I knew that if I ever was going to be well again even beyond receiving a transplant, that I was going to have to do the hard work to deal with how I was treated, to deal with the hurt and the harm that had been caused."

Her faith helped her to do the hard work of reframing her past experiences while remaining hopeful for the future:

God was all in the shift that happened in my mind. They talk about transforming your mind, I remember after those days of being unconscious, there was one day where something just shifted, where I was like, God, even if I have to deal with this physical condition and reality, I need something to happen in terms of this depression, I need my joy back, and I need to fall back in love with myself and people. I was like, that's what I need. Even if this condition never leaves me. Something has to happen there and something happened there. So, that shift, whatever that was, was all God, all the ancestors, all of my understanding of, I still have work to do in this world and in this life. My purpose has not been fulfilled. And I will make it past this. Also, I think there was a shift in my perspective where I had to stop saying, I am healing, but I had to change my vernacular and speak to my own life, in terms of saying, I am healed. I am healed. I'm healed! Meaning, in the present text. I'm well! That way of thinking, that trusting, I guess even that surrender, that I experienced, that was all God, because I was reaching within myself to figure it out and it just wasn't enough. So, I had to go beyond me and really trust in Spirit, trust in my ancestors and be like, aight Jesus, what's up?

Tamika describes a divine intervention that facilitated a shift in her perspective and behavior.

Both God and her ancestors intervened in the midst of her health crises and enabled her healing and survival. Her theology liberates her to find paths of surrender and hope that mediate the harm of her clinical mistreatment.

As we ended our interview, I asked Tamika what she hoped to accomplish by sharing her story:

By telling my story to you, by telling my story to others, by telling my story wherever I can, my hope is that women continue to speak to their pain, to speak to their hurt, and to not be silent in the face of a corrupt, unjust, evil, wicked system. I want black women specifically, to continue to speak up, and use their voices in the midst of the corruption and the - all of it! Because, the systemic change, the institutional change, the structural change, requires a number of things to be dismantled, but if I can encourage someone to use their voice and be empowered, and get the help that they need [*she clapped her hands together*], that's good with me. I'm going to bed happy.

Tamika calls for black women to speak up about the experiences of mistreatment in healthcare, for speaking up about injustice certainly contributes to the overwhelming effort needed to intrinsically transform what she describes as a "corrupt, unjust, evil, wicked system." Tamika

lives out this call to speak through her own community involvement. Before ending our interview, Tamika comments,

I'm working on building my nonprofit called, [name omitted]. Essentially speaking to prevention, speaking to what I'm calling holistic and communal care while people are dealing with these conditions where I'm wanting to set up a crisis hotline or [*inaudible*] when they're diagnosed. There isn't one in the entire country for chronic conditions. Where also I'll be pairing what I'm calling, "my [name omitted] coaches," with folks that are in the midst of conditions of the body or the mind that needs support and need help and long-term help that maybe they can't get through their insurance or isn't spiritual or doesn't speak to them in a socio-emotional way. Also going to be having support groups, and also a scholarship sort of giving component as well.

She used her experiences of pain and frustration to develop an organization centered on support. Her organization became Tamika's faithful and prophetic response to the *wicked system* of healthcare; it becomes her legacy in the lives of people and communities who survive and heal with their chronic illness, all because she told her story.

Reproductive and Maternal Healthcare

Opal - "You Should Start Asking Questions"

During much of our interview time we discussed how race and gender in particular impact the treatment someone experiences in healthcare. She shared at length about her current obstetrician, a mutual acquaintance and black woman, who Opal describes as starkly different from the physicians she encountered during her first delivery. During Opal's delivery of her daughter, physicians switched shifts in the middle of her labor. During the delivery of her son, her physician traveled back to San Diego from an out of town vacation to be there in time for her to push. Opal's outstanding care from her black obstetrician highlighted wide gaps in the care provided by the military hospital. In sharing how she would have liked to be treated during her hospitalization, Opal contends,

I would have, one, been asked is it okay for a student to do this, because this is a teaching hospital. So, that was the very first thing. They should've asked my permission. And,

then, they also have to sign for that – I actually have to sign that – and I didn’t even sign anything. Especially because I have scoliosis, and my scoliosis is to a point where it’s an actual curve, it’s an actual “S” in my back. She should’ve taken the reins then and said, “You know what, because she does have scoliosis, I can actually see the curvatures in her back, I got this.” And, she didn’t do it. Two, when it came to the whole catheter aspect of it, it should not have been a rushed experience. It should not have been, okay let’s just get it over with. No, no, no, no. It should’ve been, let’s talk through this process of how this is going to go, because one, I am a first-time mother, I’ve never given birth – I had never been pregnant before prior to my daughter, so, I don’t know what the heck is going on. Explain what is going to happen. Like, I understood that yes, a catheter has to happen because you’re not going to be up using the bathroom, so the bladder’s going to have to empty out one way or the other. But, they should’ve explained that and that’s not what they did. Ask, “okay, are you okay with us doing this even though you’re going to be able to feel it?” Or, “would you like some numbing agent so you don’t feel it?” That’s something they should’ve asked and they didn’t do it.

Opal requests thorough explanation and the acquiring of her consent. She wishes to be treated with the respect of collecting her permission for risky procedures. Furthermore, she requests to be treated with care and patience as she recovers from childbirth:

And then, the after care of actually caring for an individual. You need to check. If someone’s legs are literally, like you could take the sheets off and actually see their legs double the size of what they normally are, start asking questions, or start bringing in the appropriate resources to answer the questions that the patient has versus *oh, it’ll just go down*, or *it’s just water retention*. [Think] this might be something that might be a little more serious, we might need to take a look at versus just rushing me out the door. Like, I gave birth and 24 hours later I was out the door. Because it could’ve been something more serious. Like, it could’ve been either, I could’ve had a blood clot that could’ve killed me. It could’ve been preeclampsia and didn’t even know it. It could’ve been, gestational diabetes, luckily enough it wasn’t. So, that’s where you have all of those different aspects of it, where because they chose not to do it, because of this [*points to her face, connotes her blackness and her gender*] that something could’ve happened.

Opal credits the lack of care about her swollen legs to dismissiveness based on racialized and gender bias. She felt rushed out the hospital’s doors with limited understanding of her biological changes happening in her body. No one took the time to explain to her why her legs were so swollen and she was left to her own anxieties. Opal desires care that is thorough and consensual, qualities that would support her and her family’s health. Rather, she experienced care that harnessed the potential to cause catastrophic harm.

As we integrated spirituality into her story, Opal easily spoke to God's divine intervention in the midst of her healthcare:

I think because [God] knew the experience that I had with my first [delivery], that he knew the right people to bring into my realm for the second. Especially with all of the other elements that were coming into play of second kid, completely different gender of child that you're having, the difficulty of the pregnancy, and then the components that were going to happen after you actually give birth of [my husband's] not going to be here, and then... other factors that happened in between there that we interpersonal between me and my husband, family, so on and so forth. So, I think, God knew what to do at that particular moment in time.

An example of God's intervention in her healthcare journey was Opal's new obstetrician who delivered her son. This physician's presence in Opal's life during her second pregnancy and delivery was a symbolic act of faith in the midst of desperation:

[The physician for my second delivery] was more of an advocate, not only because yes, I am a woman of color, but I think because of that interpersonal relationship that we have too that she took the extra time. And then, even after having [my son], because [my husband] literally left for deployment, I was here by myself with the kids, she consistently checked in and that's how she was able to diagnose me with postpartum depression because of some of the things I was saying. She's like, "Ok, I need you to come into the office so we can kind of reevaluate you." Versus, with [the military hospital], they didn't even care.

Opal's new obstetrician symbolized divine justice for her past hurt. God intervened in Opal's reproductive healthcare journey and provided much needed and timely support.

God's movement in Opal's story does not, however, discount her own agency. Opal hopes that by telling her story, she can call African American women toward critically examining the healthcare system and practicing self-advocacy:

I hope that it doesn't take just an educated African American woman to start asking questions, that it should be all African American women asking. Because, you shouldn't have to know or somebody tell you, you should start asking questions automatically. Just don't accept the status quo for us. Especially in the country that we live in now, where we have the type of leadership that we have, where greed is above the sanctity of the human life. They'd rather take the money over saving a life.

Opal calls for a critique of the healthcare system that benefits from political power and greed. She calls for all black women to ask questions about their health and their healthcare and to not accept things simply being done to them in patient rooms, but to demand thorough explanation and education around clinical practices.

Tarana - “Be Our Own Advocates”

Beneath Tarana’s frustration is her fear of being judged for disclosing her cannabis use within the clinical setting. The practitioner’s comment on her cannabis use signaled inappropriate and misplaced disapproval and judgement. The practitioner’s comments fulfilled Tarana’s fear of being perceived as a careless black woman addicted to drugs, much like her mother. As we moved toward reflecting on her experience – aiming to make meaning out of her story, Tarana hunkered down on her views of cannabis and her frustration with the provider:

Jessica: If you could go back to Planned Parenthood and ask the provider your questions about birth control, how would you have wanted her to respond and treat you?

Tarana: To just not have the assumption that she needed to advise me against smoking weed. Period. Without even really understanding how my smoking weed may have been more helpful and in fact fully to my knowledge was more helpful than not smoking. Or, if you, as a healthcare provider had a concern about my weed smoking, offer alternatives. If I said to you, “Hey, I smoke weed to manage my anxiety,” give me some resources to help me get therapy. Give me resources to help me supplement whatever cost and fee for my therapist. Direct me to a group or some type of help hotline or website or some other means to get me, to redirect me, in an assisting way, rather than discouraging. Encourage me in other ways, rather than discouraging me from the path that I’m currently on. Because by discouraging me from doing the things that I’m doing right now, I don’t feel very receptive to what it is that you may be able to divulge to me. If I don’t already of alternatives, maybe it’s just because I don’t know an alternative method. And, simply by you informing me now it’s in my head and so now I can go look into those alternative methods instead. That’s more helpful.

As the provider focused on Tarana’s cannabis use, she overlooked the deeper issue of Tarana’s limited options for mental health support. It is unclear if Tarana informed the practitioner why she chose to smoke marijuana – if she told her it was to calm her anxiety when her PTSD creeps into her mind or if she told her she had no other therapeutic options at the time. But, even by

doing so, Tarana would be justifying her quite legal actions, a justification she should never need to provide.

Tarana describes herself as spiritual. Having grown up Christian and attending Catholic grade school, Tarana chose to walk away from the Church and embrace contextual spiritualities that speak to her everyday life. We explored how her spirituality intersects with her story:

I feel that my cannabis use or my marijuana use has helped me on my spiritual journey. Having [gone to a] Catholic high school and gone to a Catholic church I think that a lot of the internal questions and conversations and arguments that I have with myself and how I feel versus what the bible says and what the teachings of the church are, say, weed is the devil's lettuce outright.

Weed has helped me feel more grounded in my morals. Weed helps me treat my neighbor more kindly [*sic*]. Weed makes me feel more willing to be a productive member of society and go out and do things to contribute to society by the means of even getting out of bed to go to work. Without weed, I would just sit here. Without weed, I'd probably be homeless because I wouldn't want to do anything. And so, I felt spiritually it wasn't even much of a conversation to be had because my weed use came, or rather my spiritual growth and my spiritual journey was enabled and better by my weed use.

Tarana's appreciation and almost veneration of marijuana rationalizes the frustration and hurt she feels from the practitioner's questions. The practitioner not only questioned Tarana's cannabis use, she questioned her value system, her *raison d'être*. She questioned foundational aspects to Tarana's spirituality. Her description of her spirituality also illumines expectations of care providers.

As a spiritual being, Tarana feels grounded in her morals, she treats her neighbor kindly, and she feels productive and contributive to society. Each of these qualities she found lacking in her encounter at Planned Parenthood:

Her demeanor [was] that she didn't want to outright say "Oh, that's wrong, oh that's bad." But, her very clear word choice and rhetoric definitely stated her sentiment that she didn't really personally agree or professionally agree. Which, if you don't personally agree, this isn't the forum for that because we're not meeting on personal bounds. And if you professionally don't agree, I'm not too sure that that is the route to go professionally either. Your professional responsibility is to help me. And so, if you even felt like I was

at risk for greater drug use or for being an addict that needed therapy or needed to go to rehab, your approach didn't really help either.

The practitioner projected her morals onto Tarana by casting judgement and refrained from showing kindness as she questioned her choices. Likewise, the practitioner provided no community resources that benefitted Tarana within a society that already dealt her so much pain.

Tarana's expression of spirituality significantly differed from the other women. Although Meena describes herself as spiritual as well, she grounds herself in mindfulness practices and values the meaning of "namaste." Tarana, on the other hand, shared a sense of spiritual awareness that I only considered in regards to Rastafarianism. Her spiritual perspective was enlightening and I wondered how it would trickle into the legacy she hoped to leave by sharing her story:

I hope my interview, my experiences shared, can help you kind of pass on this knowledge to help black women feel more empowered to be our own advocates in the healthcare [system]. Whether that be simply speaking up at our appointments, whether that be being more motivated to navigate all of the red tape and the unnecessary administrative tasks that you have to do in our current healthcare system to obtain services, or even going out and becoming providers and healthcare professionals to kind of change that dynamic and change that forum. I think that all of those would be necessary and... it can really be as simple as being more cognizant to have those conversations with providers in the moment or even at the next appointment to say, you know, I kind of got the feeling of this, or you know in past appointments you expressed this, or you said this, and that's not really helpful, or it doesn't really come across as helpful or motivating so that they can be more aware of it... If you don't inform anyone they will continue to doing things the way that they do them until either they feel the need to change or it's brought to [their] attention that [they] need to change.

Tarana's hope had nothing to do with cannabis at all. Instead, she offers a call to action – to empowerment and to advocacy. Her call is for black women to speak up at appointments and to feel motivated when navigating the maze of the system. She calls for black women to hold boundary-setting conversations with their providers with the hope of inspiring them to change. Her call to action is for black women is to stop allowing providers to encroach upon their values.

Patrice - *"I'm an Expert on Me"*

The paramedic that assisted Patrice compounded unwarranted stress onto an already terrifying experience. In the midst of a miscarriage, Patrice was forced to witness her care provider ignore, and even condescend her experience. When Patrice exclaimed that was in extraordinary pain, the paramedic relayed that her pain was not too bad. When Patrice painted pictures of massive blood loss, the paramedic relayed images of minimal blood. Our next task was for Patrice to reclaim the truth she tried to speak in the back of the ambulance that day:

Jessica: If you could go back to that experience. You call the paramedics, they showed up, how would have wanted to be treated?

Patrice: Again, I think with just a deeper level of care in such a sensitive situation. Like, you don't have to go overboard and like cry when I cry, but knowing that hey, I'm here for you, just checking in with how I'm feeling. Even things that are not necessary, like, no you probably don't have to check in with me on pain every ten minutes of this fifteen-minute ride, or like every five, but in that time, just to continue to check - how are you doing? You doing alright? Is there anything I could get you? That was not even there, but could've made a big difference. Or, kind of like how you had mentioned, there could've been a way for him to relay the information, I'm sure it was time sensitive, the hospital needs to know when I get there. But, he could've said what I said verbatim, and then given his interpretation based on what he says if it was lining up with how I'm describing it. Because at least, I would've known that they've heard my concern but this is also now his take on it. I'm complaining of a lot of blood when I arrived on the scene, this is what he saw, that's fine. Because I think that would've made it less like, I didn't believe him, and more of that maybe I was frantic and scared so what I saw wasn't as much as what on the natural scale - I don't know. But, if that was the case there is a different way that he could've done that. So, I think the level of care and consideration and just I think, just kind of on a respect level. It was kind of patronizing too that he was just kind of like,

[In baby voice directed toward her] "Oh ok,"

[In a serious tone directed toward the medical staff on the phone] "Ok, there wasn't a lot of blood."

[In baby voice directed toward her] "Oh ok,"

[In a serious tone directed toward the medical staff on the phone] "No, the pain level is manageable."

Like, what?! That's not what I just told you.

More than empathy, Patrice sought validation and affirmation. She wanted her experiences of blood loss or pain to be taken seriously. She wanted the person caring for her to trust her experience and to take the appropriate actions to mediate her crisis. The paramedic's lack of

accurately relaying her pain levels and blood loss bewildered Patrice. She was left wondering why he chose to the actions he did:

I think that again, I didn't see the level of concern for what I was describing to them. Did not match their level of concern. Like, again, I'm having the regular pain, the only difference right here is that no, I don't have a big belly, but I'm having contractions! I'm having - there's stuff that is being pushed out. I know you know that because you have basic understanding of what's happening. So, why isn't your level of concern matching that?

As Patrice and I wondered about the paramedic's response to her emergency, I asked her to consider how God would speak to her in the midst of questions and reflection:

I think I definitely see [God] in everything. I think the part that I see him most divinely, it doesn't have to do with the experience of the negative experience of the paramedic and stuff like that. I think that everything happens for a reason and the fact that I had to go through this, again this wasn't planned, this was something that I think deep down we knew we weren't ready for.

She processes her treatment amongst the backdrop of her entire health crisis. Patrice views God's role in her crisis as intervening on her behalf, protecting her and her family from an unplanned pregnancy. This ultimately positive divine intervention provides justification for her terrible experience, as it was simply one part of the means to a beneficial end. Beyond God's intervention in her pregnancy, Patrice shares:

I think in this specific experience where I see the divine is that, again, it just has emboldened me... to be more of an advocate for myself, that you know, like, I've given you dominion over your body. You know when something's not right. You don't have to rely on somebody else telling you about yourself. But, you telling them, hey I need help, or I, you know, whatever, this is what I'm feeling so, which for me was not always the case... So, I think that boldness has really stepped up so that, now it's not just about me. I have to have that same type of boldness and authority for my [family]... So, I think that's been the biggest blessing and takeaway from the experience is that you have to be bold and walk in your authority and not let people tell you what and who you are and what your experience is. Because, I'm the only person that can verbalize that.

Her experience transformed the ways she approaches her health and healthcare. Her theology guides her to process her experience as a reminder of her power over body and the authority she

holds to make decisions about her health. She gained awareness of how to speak her own truth, and validate her own truth, even when no one else will.

Patrice hopes that by telling her story, black women are inspired to speak their own truths. She also departs from her story and shares about the importance of developing relationships with medical professionals that may advocate for black women in times they need it most:

Just as much as you can when you find trusted medical professionals, to keep them in your network. As much as you can. Even if something happens to where you're not able to see them for your issues, maybe for advice, maybe just for hey, is this right. Somebody that you can get a second opinion on. Because sometimes second opinions are crucial. So, just maybe somehow someday, because that's a privilege that I have, and I have to acknowledge that it's not the same for everyone. Some of these people are people that I've grown up with so that I know them through my parents. Some of these people are people that I've come in contact just because of the circles that I travel in, and that's not always the same when you look at different demographics of black women. So, as much as you can, try to always have a second opinion ready to go or somebody that you can get crucial feedback from who's going to be for your better benefit.

My second thing would be again, you have to be your own advocate. Because there's times where you're going to have to be in those spaces advocating for yourself. And, it's going to feel weird, it always feels weird when you're not in your own space. In an education space, I feel like the bomb because I know what I'm talking about. That's my craft, that's what I've studied, that's what I work on perfecting, but I don't have that same confidence and boldness when I walk into a medical office. It's not my craft. I don't know the terminology. I don't know - there's a lot of things that I don't know so it's hard to walk in that boldness in those spaces. But, you still kind of have to. You still have to. Even when you don't know the correct terminology. And they will tell you, they'll make you feel like it, oh they'll make you feel just you know, little because this is not your space. But it's like, hey, I'm not supposed to know. You are. You're supposed to know and I'm not satisfied with what you're telling me. And, boom. I need a second opinion. There's options. You don't have to take what they're giving you. I think that's the biggest thing. You don't have to take it if you don't feel like it's for your best benefit.

Her words mirrored Opal's and Tarana's who both advocate for black women to challenge their care providers until they reach mutual understanding. Patrice cautions further:

I don't want to turn that into like, don't trust doctors, because they are supposed to be trusted, but you have to be in tune with, if you know what's wrong, if you know what you're feeling, I think you kind of will already know when the doctor's telling you something if it aligns, you'll feel a certain kind of peace. It should make sense in some

general fashion. If I'm telling you I'm having issues with my heart, you are not trying to give me something for my kidney. There's something going on where I'm feeling pain *here*, you are not trying to tell me that I'm thinking of the pain here in my head. So, just kind of having that boldness to know that like, even though this is not my field and I may not know much here, I still know myself. That's where I'm the expert and where I can walk boldly and confidently in that. No, you know that stuff, but I know myself. I'm an expert on me. So, there's nothing under the sun that you could tell me that should be - I don't know not a surprise, but I know firmly and I'm present with my body, I know when it's telling me something is not right.

The trust Patrice gives to medical professionals charged with her care, is the same trust she hopes to receive in return. By boldly declaring, "I'm an expert on me," Patrice challenges her care providers to listen to her experiences and to trust her story. In Patrice's reflection is a call to build confidence. She calls for black women to trust their bodies and their knowledge of their bodies so they may be healthy and flourish for themselves and their families.

Mental Healthcare and Support

Jemel - "Put on Your Boxing Gloves"

Jemel's story of sexual harassment, misdiagnosis, and poor care was angering and saddening. I grieved for Jemel and her experience. Much time had passed since her hospitalization and our interview and I knew Jemel processed her mistreatment with mental healthcare providers. This was a significantly difficult time in Jemel's life and she sought support to move forward and regain her mental health. I asked Jemel to reclaim that moment in her life, and share how her imagination would have her be treated during a mental health crisis:

Definitely with dignity and respect, which seems simple enough. I would want for people to pay attention to me as an individual and not to whatever my ID number is or patient whoever-whomever. I would want to be treated! Because I didn't actually get treatment when I went into the hospital. So, ideally, it would be great if that happened. If I could actually get the help that I was seeking. I would want people to not be afraid of me. Especially as a black woman, and knowing that people are afraid of me just because of the color of my skin. I don't want my doctor to be afraid of me too.

Jemel hopes were modestly simple. She hoped to be treated with dignity and respect, and hoped to receive the help she initially sought. She regretted that during her three day stay at the facility, she did not receive any practical tools to manager her mental health. The psychiatrist did provide Jemel with a prescription, but, it was not fully covered by her Medi-Cal insurance and was too expensive for Jemel to afford.

The treatment Jemel endured throughout her hospitalization is unacceptable. Her story illumines the complexities of mental healthcare that the general healthcare system only builds upon. In all of that complexity and suffering, I asked Jemel to call her spirituality into her reflection on her experience:

Because it was such a hurtful experience, it's kind of hard to put God into it because the question is *God, why?* I prayed while I was there, "God, please get me out of there." So, "Why would you allow me to experience this?" I guess, is the question that I have. And, "What good can come of this?"

Unlike Tamika, Opal, and Tarana's divine intervention, Jemel grieved God's absence. She prayed for God to intervene on her behalf, to deliver her from the evil she endured. She questioned why God would *allow* her to suffer. She questioned the divine purpose of her suffering – perhaps *that* purpose was where God intervened? She paused and thought deeply at the intersection of her faith and pain:

For me, I had to pull myself together while I was in there because otherwise I would have gone crazy [*she laughs*]. I was in that situation asking myself the entire time, how was this not supposed to make me feel worse? I'm disconnected from the world, I don't have my cell phone, I don't have any clothing, I'm all these things, and so I did kind of have to pull myself together. I guess do this thing where it's like, God, I don't feel you but I still show faith, I don't see you I don't feel you but there's still a part of me that feels like I should trust you. That's kind of a challenging [question] because it's really hard to put God into that situation that was so horrible. It's almost a question of *how dare you let me experience that?*

Jemel expressed a deepening anger that grew as we continued our interview. I sensed her grief and anger with God, with God's absence, and with God permitting this experience to occur in her life. This was a painful story, and painful for Jemel to process theologically.

I asked Jemel how her hospitalization transformed her life. It left a scar that I imagined turned her world upside down. Her grief lingers in her response:

I just felt really, I don't know how to explain it, but, just really unsafe and insecure. Because the thought and the feeling was, if I can't go to a hospital to get help when I want to kill myself, then what do I do? And, I just felt straight up violated. I think I did have a lot more flashbacks because, like I said, being in there with those men who would talk to me reminded me a lot of what happened with my own experience with molestation – stuff like that – it brought back flashbacks to those instances of what happened to me. So, I did get that a lot afterwards. I don't want to say I felt dirty, but I just felt really exposed. And, again, there was no one there to protect me, because people were watching this happen. People can see me in pain, people can see this happen, and not say a word. What does that mean? What does that look like?

I quickly attempted to affirm Jemel in her vulnerability and reflected back what she shared with me. I hope she felt heard and believed. I shared with her a story of my own where I felt disrespected during a clinical encounter that left me angry and distrusting of healthcare providers. While I shared, she nodded in agreement and affirmation. In that moment, we centered vulnerability.

To further affirm the courage in her sharing, I asked Jemel what she hoped would come of her sharing her story. She first shared how her own story inspired her:

[My story] inspired me to want to somehow make a difference in the field. To, like I said, either share my story, or even as an ethicist, if I can somehow express to people what happened and how this is not okay... And I'm more of an advocate for myself when it comes to when I have to go to the doctor and deal with them. I treat them a lot differently in the sense of I do my research before I show up and I make sure I tell them I know this information so this is what I'm expressing to you and I need you to help me. And so, there is no longer an assumption that the doctor has my best interest in mind. It's always the assumption that I have my best interest and I need to fight for it.

Jemel echoes Patrice's declaration: "I'm an expert on me!" She found confidence to advocate for herself and developed skills like preparing herself with information before clinical encounters. Her experience of mistreatment did result in a distrust of physicians as she will no longer assume they have her best interest in mind. She takes up a defensive stance, believing she must fight for her health. Consequently, Jemel encourages black women to take up the fight themselves, calling black women to prepare for resistance:

You have to be an advocate for yourself. You have to fight for yourself. Because people don't trust you, people are afraid of you. People make assumptions about you. I think that being a black woman, it's almost like, put on your boxing gloves. You have to go in there ready to fight. If you really have something wrong with you, if you're really seeking to get the help that you need, you have to go in there willing to fight and to really advocate for yourself.

She concludes with one final thought for black women as they navigate mental healthcare:

"Know your rights and your laws. Because even with me knowing them, they still didn't respect them."

Meena - "Everybody's Connected, We're All the Same"

Meena's spirituality guided her meaning making process much like the other women. Although she did not share about her experiences of mistreatment in the traditional American healthcare system, her story demonstrates a concern that requires further exploration. African American women *are* seeking alternatives to U.S. healthcare models. Their distrust and the cultural irrelevancy of U.S. healthcare pushes black women toward holistic practices such as reiki. Meena's story of mistreatment beyond the walls of traditional healthcare demonstrate that pervading the healthcare system is not a unique disease, impossible to identify and cure, but is simply racialized bias, born of white supremacy, and spreading rapidly. Like my other research partners, I asked Meena to picture herself reentering the moment of her encounter and imagining how she would have wished to be treated:

I just would have wanted to be greeted with like – because you can sense when other people are uncomfortable as well. So, I could feel that they weren't comfortable with me either. So, I would have liked to feel like they were comfortable with me. And, of course they were customer service friendly, but just like more welcoming and warm.

Meena hoped for hospitality, for warmth, and to not feel the uncomfortable gaze of judgment or bias.

Her spirituality speaks to her vision of appropriate treatment in alternative healthcare:

I believe in the universe. I believe in a higher power. I believe that different cultures will define this higher power as different things. And I think that that should be respected... I think as long as you have good intentions...I'm open to what different religions have to say. And... I feel like I have my own personal relationship with the divine. That to me is the most important.

The more that I personally learn about spirituality and all of that stuff, is like, first of all if it's anything tied into yoga, because that reiki place was also, they offered yoga there. But the whole thing with "namaste," everyone says "namaste, namaste, namaste," but they don't actually know what it means. It means that everybody's connected, we're all the same. So, I really get thrown off when places are not welcoming, or I see like them treating certain demographics differently. Because the whole thing is that we're all the same. I think, like so also having more education in what their craft is.

Meena expects for her care providers to embody the spirituality she practices. As Meena respects differences in cultures, perspectives, and humanity, she expects for her care providers to do the same.

Meena calls for holistic health providers that claim to embody the principles of *namaste* to evaluate how they practice their values:

Namaste means that my soul honors your soul. I honor the place in you where the entire universe resides. I honor the light, the love, the peace, the truth, and the beauty within you because that is also within me. In acknowledging we are the same, we are connected, we are one. I understand what it means. And, I intend to practice it whenever I teach my classes. I explain the meaning of what namaste means because I think it's important and I will continue to do that as I teach. Every single class I say it at the end... I do try my best to make people feel comfortable just being themselves, that's my biggest thing as a yoga instructor myself, or just as a social worker, and as a person, as a friend, I always want to make people feel comfortable being themselves in their skin.

Meena works to embody the principles of *namaste* in her holistic care practice. Her commitment to living out her values as a yoga instructor, friend, and social worker, speaks to her expectation of other care providers doing the same. As we ended our interview, I asked Meena how she hopes her story transforms or improves the way African American women are treated in the healthcare system. I wondered if her response would apply only to particularities of holistic health care. Like her practice, her response aligned with her values of *namaste*: “I just hope that the people who need help, are given the help that they need without judgement, or any sort of assumptions.”

Summary and Next Steps

Emerging from these living human narratives are women embracing self-empowerment, self-advocacy, communal advocacy, and hope. They critique the healthcare system with bold voices of frustration, disgust, and heartbreak telling important stories of racism, sexism, and classism. Their critiques shed light on the bias that occurs within the halls of healthcare as they call attention to their mistreatment. And, while this critique of healthcare systems contributes to change, the women also shared how, despite the racism, sexism, and classism in their stories, they continued to seek treatment, continued to manage their illnesses, continue to advocate for their health, and continue to survive and thrive for themselves and their families. Their resilience offers creative space for the reimagination of healthcare systems. Notes of hospitality, respect, and trust flow from their words. They imagine a system where African American women are no longer mistreated and safe to seek the treatment they need.

In the following chapter, a confluence of metatheory and method in womanist and African American psychologies and womanist pastoral theology produces a hermeneutic of

womanist psychospirituality to interpret these living human narratives. Womanist psychospirituality describes African American women's emotional and cognitive processes of meaning making and healing for both themselves and their communities in light of psychological, social, and political challenges. Both womanist and African American psychologies attest to the integration of the psychosocial and spiritual aspects of African American life as contributive to the development of culturally rooted value systems. Meanwhile, womanist pastoral theology examines African American women's use of spirituality to cope, make meaning, and thrive in society. Womanist psychospirituality interweaves these methods, theories, and Hagar narratives of the Hebrew Bible to create a hermeneutic that identifies language rooted in African American spiritual values that signal codes for survival and flourishing in systems rooted in American values of oppression. African American women use spirituality to cope and make meaning out of their health experiences as well as experiences of injustice such as racism and sexism. Engaging their stories through a womanist psychospiritual lens elucidates how black women make meaning out of their mistreatment and maintain their resilience and resistance despite mistreatment.

CHAPTER 7

INTERPRETING LIVING HUMAN NARRATIVES:
HERMENEUTIC OF PSYCHOSPIRITUALITY

Thinking with a Hermeneutic of Psychospirituality

Following the women sharing their stories of mistreatment, we shifted our conversation to uncovering how they reclaimed and made meaning out of their experiences, and how they hoped their experiences could impact the lives of other black women entangled in systems of healthcare. Each woman's capacity to reclaim how they wish to be treated, make meaning out of their story, and articulate the hopes of their narrative legacies is rooted in her spirituality. African American women display extraordinary ways of coping, thriving, and growing despite significant psychological, social, and political challenges.¹⁸⁰ Black women's spirituality is a renowned form of strength and resiliency passed on through generations. Black women's spirituality informs the meaning they prescribe to their experiences and how they relate to themselves and others based on those experiences. It creates space to recognize and name one's own mistreatment in society, to claim boldly how one wishes to be treated by oppressors, to trust the divine's intervention in attaining just treatment, and to share one's story for the benefit and liberation of others.

This *womanist psychospirituality*¹⁸¹ is a confluence of metatheory, method, and assessment in African American psychology, womanist psychology, and womanist theology.

¹⁸⁰ Thema Bryant-Davis and Lillian Comas-Díaz, "Introduction: Womanist and Mujerista Psychologies," in *Womanist and Mujerista Psychologies*, ed. Thema Bryant-Davis and Lillian Comas-Díaz (Washington D.C.: American Psychological Association, 2016), 3.

¹⁸¹ Lillian Comas-Díaz, "Mujerista Psychospirituality," in *Womanist and Mujerista Psychologies*, ed. Thema Bryant-Davis and Lillian Comas-Díaz (Washington D.C.: American Psychological Association, 2016), 149-169.

Womanist psychospirituality describes black women's emotional and cognitive processes of meaning making and healing for both themselves and their communities in light of psychological, social, and political challenges. Womanist psychospirituality provides womanist clinical pastoral theology with a clinical-contextual lens for understanding the inner psychospiritual world of African American women and how they come to make meaning out of their lived experiences. African American and womanist psychologies affirm the integrated psychosocial and spiritual aspects of African American life as contributive to the development of culturally rooted value systems while womanist pastoral theology validates African American women's use spirituality to cope, make meaning, and thrive in society.

Both womanist and black psychologies are positive psychologies that "promote positive human strengths and living well."¹⁸² Womanist psychology is culturally and strengths-based in that its focus goes beyond pathology and oppression to the development of optimal psychological and collective well-being of African-descended women and all of humanity, across race and gender lines. Womanist psychological theory is also a liberation-based approach based in the idea that difference does not equal deviance.¹⁸³ Likewise, "Black psychology is built on the principle that black people have significant strengths."¹⁸⁴ African American or black psychology responds to collective encounters with oppression, recognizing that these collective

¹⁸² Caldwell-Colbert, Parks, and Eshun, "Positive Psychology: African American Strengths, Resilience, and Protective Factors," in *Handbook of African American Psychology*, ed. Helen A. Neville, Brendesha M. Tynes, Shawn O. Utsey (Thousand Oaks, CA: SAGE Publications, 2009), 376.

¹⁸³ Bryant-Davis and Comas-Díaz, "Introduction: Womanist and Mujerista Psychologies," 11.

¹⁸⁴ M. Nicole Coleman and Adanna J. Johnson, "Sankofa: History of and Aspirations for Black Psychology Through the Eyes of Our Elders," in *Handbook of African American Psychology*, ed. Helen A. Neville, Brendesha M. Tynes, Shawn O. Utsey (Thousand Oaks, CA: SAGE Publications, 2009), 27.

encounters also subversively create notable strengths such as hope, optimism, and resiliency.¹⁸⁵ Black psychology pays particular attention to the influence of these encounters on the mental health of black people, thereby seeking to improve their mental health by remaining committed to liberating black people from the confines of structural racism.¹⁸⁶ Similarly, metatheory in African American psychology, womanist psychology, and womanist theology is grounded in black lived experience. They each challenge traditional epistemologies by privileging stories and experiences from the margins.¹⁸⁷ Black and womanist psychologies as well as womanist theology use lived experience as the point of departure for their inquiry. A womanist psychospirituality gleans from these spaces of intersection.

Spirituality as Coping

African American psychology responds the impact of white supremacy and racism on the collective psyches of African American people. Despite the public disavowal of racism and white supremacy, their ideologies continue to permeate spaces in society wreaking havoc on the well-being of those impacted by the social inequity it causes.¹⁸⁸ Helen A. Neville and Alex L. Pieterse describe race-related encounters and race-related stress as resulting in overtaxing individual or collective resources to cope and threatens well-being.¹⁸⁹ Experiences of race-

¹⁸⁵ Linda James Myers, "Theoretical and Conceptual Approaches to African and African American Psychology," in *Handbook of African American Psychology*, ed. Helen A. Neville, Brendesha M. Tynes, Shawn O. Utsey (Thousand Oaks, CA: SAGE Publications, 2009), 35.

¹⁸⁶ Coleman and Johnson, "Sankofa," 27.

¹⁸⁷ Bryant-Davis and Comas-Díaz, "Introduction: Womanist and Mujerista Psychologies," 11.

¹⁸⁸ Helen A. Neville and Alex L. Pieterse, "Racism, White Supremacy, and Resistance," in *Handbook of African American Psychology*, ed. Helen A. Neville, Brendesha M. Tynes, Shawn O. Utsey (Thousand Oaks, CA: SAGE Publications, 2009), 162.

¹⁸⁹ Neville and Pieterse, "Racism, White Supremacy, and Resistance," 163-164.

related encounters and stress are associated with symptoms of depression, anxiety, and psychological distress as well as heart disease, low birthweight, hypertension, and glucose intolerance.¹⁹⁰ However, studies also demonstrate, that African Americans foster incredible tools for agency and resistance.¹⁹¹ For example, Shorter-Gooden's 2004 study showed that black women cope with racism through internal strategies such as faith and self-esteem, external strategies such as social support, and culturally-specific coping strategies including fighting back.¹⁹² Of note for this womanist psychospirituality framework is the role of this faith or spirituality and fighting back in the inner-world of African Americans as they cope.

African American psychology acknowledges spirituality as a protective factor for black individuals, families, and communities coping with oppression. Caldwell-Colbert, Parks, and Eshun identify spirituality as a critical source for resiliency and coping as it inspires optimism and hope of deliverance from oppressive forces.¹⁹³ In their essay, Caldwell-Colbert, Parks, and Eshun aver that spirituality shapes the lives of African Americans including cognitive appraisals and meanings attached to challenges.¹⁹⁴ Spirituality informs how African Americans understand and make meaning out of the challenges they face.

As Alicia reflects on her mistreatment, she shares gratitude for her experience. She notes that as she reflects on and continues to make meaning out of her mistreatment and her diagnosis, she found stronger faith as well as her voice. Her spirituality served as a coping mechanism that allows her process and make meaning out of her condition over time. Alicia testified, "thank you, God, for allowing me to be an advocate." Her spirituality as a coping mechanism fostered a shift

¹⁹⁰ Neville and Pieterse, "Racism, White Supremacy, and Resistance," 167.

¹⁹¹ Neville and Pieterse, "Racism, White Supremacy, and Resistance," 167.

¹⁹² Neville and Pieterse, "Racism, White Supremacy, and Resistance," 168.

¹⁹³ Caldwell-Colbert, Parks, and Eshun, "Positive Psychology," 379.

¹⁹⁴ Caldwell-Colbert, Parks, and Eshun, "Positive Psychology," 380.

in how she perceived her experience. Alicia used her experience of mistreatment and multiple sclerosis as a starting point for her work in disability advocacy.

Patrice sees the divine in her shift from passivity to boldness. Patrice sees God in her desire to advocate for herself and declare *dominion* over her body. Through her spirituality as a coping mechanism, Patrice learned to “not let people tell [her] what and who [she is] and what [her] experience is.” She grew in her own self-confidence and security in her body-knowledge and believes that this shift does not only benefit her but her family as well.

Tamika began to trust in Spirit, her ancestors, and Jesus as she searched for ways to *figure out* how to navigate her healthcare. She notes, “I was reaching within myself to figure it out and it just wasn't enough.” She in turn trusted in the divine and declares that a shift took place once she did. This divinely orchestrated shift contributes to her new nonprofit which targets people of faith with chronic illness. Tamika was alone in her wilderness and used spirituality to assist her in finding a sense of healing and purpose that benefits her community.

Through a foundational commitment to spirit, womanist psychology recognizes the role of spirituality in the pursuit of black women’s “knowledge, meaning, transcendence, hope, connectedness, and compassion.”¹⁹⁵ In womanist psychology, *spirit* is acknowledged as a driving and motivational force in black women’s lives and a significant factor to their psychological functioning.¹⁹⁶ Spirituality assists women in coping with the oppressions they encounter every day, allowing them to reframe their experiences and develop resiliency.¹⁹⁷

¹⁹⁵ Bryant-Davis and Comas-Díaz, “Introduction: Womanist and Mujerista Psychologies,” 10.

¹⁹⁶ Bryant-Davis and Comas-Díaz, “Introduction: Womanist and Mujerista Psychologies,” 12-13.

¹⁹⁷ Bryant-Davis and Comas-Díaz, “Introduction: Womanist and Mujerista Psychologies,” 12.

Banks and Lee identify spirituality as, “a buffer for African American women exposed to individual and/or institutional racism,” as well as, “a critical factor in the health of African American women, especially in coping with illness.”¹⁹⁸ Combining both emotional and cognitive processing, spirituality becomes critical in the psychological functioning of African American women who simultaneously encounter both institutional racism in healthcare and health crises, much like Alicia, Stacey, Opal, Patrice, Jemel, Tarana, Tamika, and Meena.¹⁹⁹

Spirituality and Healthcare Values

Bryant-Davis and Comas-Díaz purport, “Spirituality infuses women’s development with values such as compassion, tending, and care... Moreover, spirituality affirms women of color’s values of connectedness, and interrelatedness.”²⁰⁰ Spirituality informs the development, articulation, and practice of black women’s values as they engage in religion and spirituality in search for meaning and relationship.²⁰¹

Stacey begins to make meaning of her experience as she works to compare divine-qualities such as *comforter* with the behavior of clinicians. She names *acknowledgment* as an action that may to cause patients to feel comforted while preventing patients from feeling lonely. Because God acknowledges human experience and in turn offers comfort, she expects her care providers to do the same. As she uses her spirituality to make meaning out of her experience, Stacy’s spirituality begins to shape her values of healthcare.

¹⁹⁸ Banks and Lee, “Womanism and Spirituality/Theology,” 127.

¹⁹⁹ Banks and Lee, “Womanism and Spirituality/Theology,” 128

²⁰⁰ Bryant-Davis and Comas-Díaz, “Introduction: Womanist and Mujerista Psychologies,” 13.

²⁰¹ Martha E. Banks and Stephanie Lee, “Womanism and Spirituality/Theology,” in *Womanist and Mujerista Psychologies*, ed. Thema Bryant-Davis and Lillian Comas-Díaz (Washington D.C.: American Psychological Association, 2016), 125.

Meena shares her growing frustration in reiki and yoga studios that proclaim a sense of namaste but are rather unwelcoming toward their black women consumers. For Meena, namaste means “we’re all connected, we’re all the same,” and she expects other practitioners who integrate the concept of namaste into their practice to share her same spiritual values. Meena’s spirituality shapes her values around holistic healthcare and she prefers holistic health spaces that also believe in unity and connection much like her.

In asking Tarana about her spirituality, she responds, “Weed has helped me feel more grounded in my morals. Weed helps me treat my neighbor more kindly [*sic*].” For Tarana, her cannabis use supported her spirituality and served as a spiritual practice. Through cannabis, she was kinder and felt grounded in her own value system. Tarana grew frustrated as she perceived her provider to be projecting *her* values onto Tarana. The provider’s criticism of cannabis and projection of her values was in direct violation of Tarana’s spirituality.

Womanist psychologist Janis V. Sanchez-Hucles describes African American women as flexible and dynamic in their emotional expression, seek liberation from oppressive confines of society, believe in the power of their cultural identities strive to share that power among all people, and believe that all people are connected.²⁰² Womanist psychological inquiry illustrates how spirituality impacts the psychological functioning of African American women and illustrates how their unique lives and perspectives contribute to the development of their values, how they relate to themselves, and how they relate to the others.

²⁰² Sanchez-Hucles, “Womanist Therapy with Black Women,” 73.

Making a Way Out of No Way

Delores S. Williams provides a womanist theology rooted in doctrine of salvation. Her womanist god-talk sheds light on black women's spiritualities and their collective understanding of the divine *making a way out of no way* in the midst of multivariate oppressions. In *Sisters in the Wilderness*, Williams begins with the Hagar-Sarai-Abram stories of Genesis. In Genesis 16, Hagar, a young African slave, serves as the surrogate of Sarai, her owner, who's barrenness threatens the legacy of her and Abram's family. After *mistreatment* by Sarai, a pregnant Hagar flees into the wilderness where she encounters God. During this divine intervention, God first asks, "Hagar, slave-girl of Sarai, where have you come from and where are you going?"²⁰³ Thus allowing Hagar to both reclaim her past and claim her future.²⁰⁴ God then instructs Hagar to return to Sarai's home, concerned for her and her unborn son's survival alone in the treacherous desert. Williams speculates that this concern may be related to both the high rates of infant mortality in the ancient Near East and with God's concern for Hagar's quality of life.²⁰⁵ Ensuring resources for her survival became crucial as God finally promises Hagar a multitude of offspring – a legacy – in return for her surrogacy. In Genesis 21, Hagar and her son Ishmael are now cast out of the family's home by Sarah. Hagar and Ishmael travel alone in the wilderness before finally running out of resources. Hagar sits her son down beneath a bush and sits far enough away from him so that she does not have to bear watching him die. It is in this moment of despair, in the middle of the wilderness, that God intervenes once more, providing Hagar and her

²⁰³ Gen. 16:8 (NRSV).

²⁰⁴ Delores S. Williams, *Sisters in the Wilderness: The Challenge of Womanist God-Talk* (Maryknoll, NY: Orbis Books, 1993), 20.

²⁰⁵ Williams, *Sisters in the Wilderness*, 21.

son with not only the resources to survive in that moment, but by securing the family's legacy for generations.

Williams situates Hagar's poverty, socioeconomic status as a slave, foreignness (African), and female body at the center of her problems. She writes, "the slave woman's story is and unavoidably has been shaped by the problems and desires of her owners."²⁰⁶ Williams suggests that Hagar's experience as an oppressed African woman resonates deeply with African-American women today. She refers to the symbolic term *wilderness* or *wilderness-experience*, often used by black Christian women describing, "a near-destructive situation in which God gives personal direction to the believer and thereby helps her make a way out of what she thought was no way."²⁰⁷ At the end of *wilderness-experiences*, black women find self-advocacy, courage, independence, and self-determination, and renewed sense of relationship with the divine.

Hagar-in-the-wilderness symbolism represents faith experiences that shape the lives of African-American women. The symbolism bears hope for black women's collective struggle for survival and liberation in the midst of social, political, and economic oppressions.²⁰⁸ Williams asserts, "Thus we can speak of Hagar and many African-American women as sisters in the wilderness struggling for life, and by the help of their God coming to terms with situations that have destructive potential."²⁰⁹ Black women's connection with Hagar extends beyond God's divine intervention in their lives. Like Hagar, African American women experience extreme mistreatment due to their intersectional identities as African (black) and female. Surrogacy

²⁰⁶ Williams, *Sisters in the Wilderness*, 15.

²⁰⁷ Williams, *Sisters in the Wilderness*, 108.

²⁰⁸ Williams, *Sisters in the Wilderness*, 119.

²⁰⁹ Williams, *Sisters in the Wilderness*, 109.

practices and forced reproduction during American slavery, and eugenics practices that persisted into the twentieth-century, for instance, demonstrate African American women and their resonance with Hagar's pain. It is because of this resonance, that for Williams, any image of atonement must not center Jesus's surrogacy. She suggests that Jesus's salvific power was rooted more so in his life of ministry – as a healer and teacher – rather than in his surrogate death. Liberating Jesus from this image of surrogacy ultimately liberates black women from their collective and historical pain.

Many of my research partners shared about God's intervention, or lack thereof, in either their health journeys overall or their stories of mistreatment. Many described how the divine made a way for them to heal, find courage, and spaces of advocacy for themselves and others in the midst of challenging diagnoses and triggering treatment.

For Opal, because God knew intimately well her experience of mistreatment, God in turn placed "the right" people in her life to prevent mistreatment from reoccurring. God intervened during Opal's wilderness experience and redirected her towards new and beneficial relationships to ensure her and her family's flourishing. God assisted Opal in making a way through this wilderness and securing her health and her future generation's health through her new obstetrician.

As she reflected on her the clinical encounter Jemel recalls, "I prayed while I was there, *God, please get me out of there.*" Jemel prayed for the divine to make a way through the wilderness of the psychiatric hospital. She prayed for God to rescue her from her mistreatment. When no rescue came, Jemel felt compelled to turn to God and cast blame for her experience. She posits, "It's almost a question of *how dare you let me experience that?*" Jemel was in her

wilderness during her hospitalization. She expected for the divine to make a way out of her wilderness experience and grieves that the divine never came.

It was only after the interviews, and in revisiting Williams' text, that I found parallels in her interpretation of Hagar's story with the narratives of meaning making. It is in the wilderness where Hagar encounters the divine who asks her, "where have you come from and where are you going,"²¹⁰ inviting Hagar to speak to both her past experience of mistreatment and to claim her hopes for her future. My research partners did so as well. God then instructs Hagar to return home with concern for her and her family's health and quality of life. The women spoke of God's concern for them in a time when they needed divine guidance in the midst of their healthcare and health journeys, or when their quality of life was in jeopardy. And finally, Hagar's actions ensured a legacy she could only imagine. I hope these women's actions – telling their stories – does the same.

Summary and Next Steps

Creating a framework for womanist psychospirituality assisted in engaging how African American women name their past experiences and future hopes, find spaces of spiritual and divine intervention, and cultivate a legacy from their stories of pain. Womanist psychospirituality assists in interpreting the living human narratives of black women as reliant consumers of American healthcare despite their messy and abusive history. Womanist psychospirituality helps us to understand how African American women continue to use a system that wreaks of white supremacy, judgement, dismissiveness, apathy, disrespect, and negligence and that has yet to demonstrate reverence for their bodies. It helps us to understand how, despite experiences of

²¹⁰ Gen. 16:8 (NRSV).

mistreatment, African American remain hopeful for a time when their bodies are no longer subjected to a white, sterile gaze, but are rather finally included in patient-centered care. Womanist psychospirituality illuminates the ability to cope with delicate health while coping with nasty healthcare systems.

Rooted in the call-and-response tradition of African American culture, within each woman's narrative of meaning making is a call beckoning for a response. These calls guide the *response* aspect of this dissertation's methodology of listening, interpreting, and responding to living human narratives. The following chapter provides both the calls from Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena as well as my response to their living human narratives rooted in the indigenous practices of black birthwork. I hope to begin conversation on the role of black birthworkers, doulas, midwives, and those trained in the tradition of "granny midwives," in the interruption of mistreatment and the reimagination of healthcare for African American women.

CHAPTER 8

RESPONDING TO LIVING HUMAN NARRATIVES:

BIRTHWORK IS SPIRITUAL CARE

It's definitely scary for black women, for all health, but especially in childbirth because we have the highest mortality rates. You think you're going in and having a baby and you come out, the baby's here but you not. That's awful. I was speaking with [a friend] when she, as you know, she was expecting, and I told her about how I had a doula, and how it was so great because I gave birth naturally, I didn't want medication. And, that's usually why you get a doula, if you are planning on having an unmedicated birth. She was like, well, I'm not sold on being unmedicated but I still want a doula. I was like ok, you know, most times, they're not covered by insurance, you're gonna have to come out of pocket for it... But, as I was explaining this to her she was like, "Yeah, but you know our mortality rate is higher, and I think it would just be beneficial for me to have an advocate in the room for me who knows about childbirth." And I mean, it completely like slapped me in my mouth. I was like, "I didn't think about it that way." I did not think about it that way at all. I'm so happy my doula was in the room with me. The situation was different but even so, I still would've wanted her in the room with me because she was so amazing.²¹¹

The final methodological practice for this womanist clinical pastoral theology's framework of listening, interpreting, and responding is to respond to the living human narratives. This chapter begins by naming eight calls put forth by the women as each claimed her hope for care. I situate these calls within a call-and-response discourse mode. I respond to these calls and the living human narratives by exploring the world of black indigenous birthwork as spiritual care. A response is not conclusive. It opens dialogue and invites ongoing wondering, investigation, and critique. In continuing with Jackson and Mazzei's analytical concept of thinking with theory, I resist drawing any conclusions at all. Rather, I see this research as a way

²¹¹ Excerpt from Patrice's interview transcript.

to begin a new conversation to think about how the field of pastoral theology can approach African American women's healthcare.

This chapter further examines how the “plugging of theory into data into theory not only produces new analytical questions, but also produces different researcher selves.”²¹² Engaging in this critical narrative research process informed how I view the possibilities of pastoral theological exploration and inspired me to push the boundaries of what constitutes as traditional pastoral care. This chapter explores how this research process “made and unmade”²¹³ me and birthed theological interest in birthwork as spiritual care and as that which can interrupt mistreatment through a contextual clinical pastoral paradigm.

Calls-for-Response

Out of each woman's individual narrative and out of the women's collective voices emerges calls-for-response. In privileging oral communication as rooted in African-based oral traditions and African American culture, I identify each women's hope for change as a *call* within a call-and-response discourse framework. On call-and-response discourse, Collins writes, “Composed of spontaneous verbal and nonverbal interaction between speaker and listener in which all of the speaker's statements, or “calls,” are punctuated by expressions, or “responses” from the listener, the Black discourse mode pervades African-American culture.”²¹⁴ The women's living human narratives offer calls that beckon active responses from their listeners.

Alicia's living human narrative calls for African American women patients to educate care providers around issues of cultural competency. She notes that building relationship with

²¹² Jackson and Mazzei, *Thinking with Theory*, 137.

²¹³ Jackson and Mazzei, *Thinking with Theory*, 137.

²¹⁴ Collins, *Black Feminist Thought*, 261.

her provider contributed to better communication and interrupted her persistent mistreatment. Tamika calls for black women to speak up about their healthcare experiences to bring light to systems of injustice and corruption. She believes that in sharing stories of mistreatment, the system may begin to transform. Opal calls for all black women to ask questions about their health and healthcare, thinking critically about procedures, diagnostics, and even medications. She calls for demanding thorough explanations and securing informed consent. Tarana's call is for black women to hold boundary-setting conversations with their providers with the hope of encouraging them to respect differences in values and coping strategies.

Patrice calls for black women patients to seek care with confidence and self-assurance, trusting, honoring, and communicating their own knowledge and awareness of their bodies. Jemel calls black women patients to prepare to fight for the treatment they deserve. She cautions black women to prepare for resistance as they seek just and safe treatment. Stacey calls for providers to be mindful of how they communicate their opinions and assumptions. She recalls the words of a pediatrician that left a lasting impact on how she navigates care today. Meena calls for holistic health providers to practice the values they communicate printed in their literature and painted on their walls. She calls for practitioners of reiki to practice their espoused value *namaste* and radical hospitality. I categorized these various calls into four calls for providers and four calls for African American women patients.

Calls for Providers

Call for trusting black women's stories

Meena simply wished to be trusted by the staff at the reiki studio that she would not steal their merchandise. Jemel hoped to form trust with her care providers rather than fear. Her psychiatrist acted fearful of Jemel with no apparent reason, leaving Jemel feeling categorized and

criminalized before even introducing herself. Alicia wants to be treated as if she knows her body better than anyone else. She wants to be trusted when she shares symptoms, not ignored due to racialized stereotypes such as *black women don't get MS*. Patrice also wishes to be trusted. She wants to be believed when she tells paramedics her level of pain because she, more than the paramedic, knows her body.

The historical and socio-theological assumptions that women, and black women in particular, could not be trusted continues to pervade healthcare. The patriarchal social control of women, justified by skewed Christian theology, colors issues of trustworthiness within clinical settings. Images of black women as untrustworthy deviants, deserving of scientific intervention such as eugenics or social interventions such as mass incarceration trickles into contemporary institutions. Similar to slogans sung in the reproductive justice movement, a cry to *trust black women* calls out to healthcare systems. Trust emerges from the stories as a multifaceted womanist value in the provider-patient relationship. One aspect of trust centers black women as fully capable of accurately describing their own physical feelings and sensations and calls for providers to wholeheartedly trust their accounts. Trusting black women also declares that black women deserve to not be treated as suspicious, untrustworthy, or frightening. Their presence should not be criminalized. Trusting black women in the American healthcare system looks like centering black women's accounts of their own health and decriminalizing the presence of African American women in clinical settings.

Call for hospitality

Meena repeatedly expressed her value for hospitality. She hoped for a welcoming and comfortable environment that embodied the principles of *namaste*, a guiding system of ethics that she felt integral to reiki practices. The studio's lack of following *namaste* in their attitudes

and behavior caused dis-ease and discomfort in Meena's spirit. Opal's call of hospitality shows up in her wish for her care providers to provide better explanations for their procedures and to take time to answer questions. Their lack of patience and sense of urgency, from the epidural to dismissing her swollen legs, translated into a lack of hospitality. Similarly, Patrice wishes the paramedics would have checked in with her or asked her if she was okay. Patrice simply wanted hospitable, courteous, and professional concern for her well-being during an excruciatingly painful miscarriage as she rode in the ambulance with strangers.

Due to what I consider a healthy suspicion of healthcare systems – holistic or otherwise – it is not surprising that black women search for spaces where they feel welcome, safe, and cared for. Safe and welcoming spaces of black healing are sacred and liberated spaces. The nation's current mainstream medical system arrived to North American shores from Europe at the same time the first Africans arrived from their homelands. Americans of African descent have never had a hospitable relationship with the traditional American healthcare system and experiences such as Meena's casts a dreary vision for non-traditional health practices as well. The uncomfortable, inhospitable, and unwelcoming white gaze pervades all care practices. Likewise, community, nurturing, relationship, and hospitality are integral to black life. It is within community that these safe spaces for nurture and healing are brought to life. But, communal spaces are not always accessible or sufficient for matters of emergency such as that of Patrice. Calling for hospitality in healthcare settings provides black women with safe and welcoming spaces to heal without fear of mistreatment. They are allowed to be vulnerable guests in clinical settings because they trust they will be warmly cared for.

Call for questioning one's assumptions

Tarana, Opal, and Stacey each noted the importance of care providers asking questions. Tarana is concerned the nurse practitioner made assumptions about her character, her health, and her behavior based on disclosing her cannabis use for medical purposes. She wishes the nurse took the time to ask questions rather than assume she needed to quit. Opal wishes the staff asked for her care preferences and her consent rather than assuming her comfort with a student administering her epidural. She felt their assumption about her comfort with the student was based in racialized bias. Stacey wishes her providers, particularly her physician in seventh grade, refrained from making assumptions about behavior as a preteen girl. She also wishes the physician in her adult encounter chose to take the time to make a well-informed diagnosis, rather than quickly writing a script for hemorrhoid cream. Meanwhile, Tamika values having wider and diverse perspectives when engaging in clinical care. She feels providers assumed that every reason she presented to the emergency department pertained to her kidney disease. When she presents to the hospital with a concern such as chest pain, she wants to be treated for the concern *she* cares for at the time, not as nephrology research.

We all make assumptions out of our biases and prejudices. Awareness of these assumptions and their role in the clinical encounter mediates the potential emotional hurt that Tarana, Stacey, Opal, and Tamika all experienced in their care. Patient-centered-care trusts that care providers privilege the patient's care needs over institutional goals. Questioning one's assumptions in clinical care encounters begins with patient-centered-care that also privileges the patient's care needs over the provider's personal opinions about the patient's behavior. Care providers can learn what is important to the patient through asking pertinent questions and engaging in open dialogue. Asking pertinent questions can also prevent assumptions in

providers' clinical assessments. Asking questions and suspending assumptions in healthcare goes beyond valuing providers' awareness of their own implicit bias and involves providers taking responsible action to engage with their own cultural countertransference, set aside pride to ask clarifying and appropriate questions, and recognize when their racialized or gendered assumptions cloud their clinical care.

Call for respecting black women's body-knowledge

Tarana wished the nurse practitioner at Planned Parenthood took the time to ask questions and really understand her cannabis use before deciding her opposition. Tarana sensed a lack of respect of her choices – choices she made due to limitations she experienced in the healthcare system itself. Jemel specifically asks for healthcare providers to pay attention to her as an *individual*. She asks to be treated worthy of safety and support from the staff that witnessed her harassment but neglected to intervene. Opal simply desires the respect of consent. She wanted the respect of being asked her permission before the student administered her epidural. Alicia shares that she wanted to *feel heard* to which I interpret as wanting the respect of being listened to when she speaks. Both she and Stacey deserved the respect of adequate and timely screening and exams – not delayed and misdiagnoses. Tamika expressed frustration in being left in the hallway of the emergency department with no sense of urgency from the staff to move her. Tamika wanted the respect of urgency and concern. Tarana, Jemel, Opal, Alicia, Stacey, and Tamika expressed a deep value for respect from providers and staff while seeking care. Respect also runs through Meena's and Patrice's stories as well. Being trusted by care providers, receiving hospitality, and being greeted with questions rather than assumptions all express sincere respect for the patient.

Black women, their knowledge, and their bodies are worthy of respect. African American women receive respect in very little spaces in American society. Their intersectional identities often render them standing in marginal trenches fighting for their voices to be heard and fighting to be treated with dignity and decency. This battle for respect occurs not only along racial lines, but along gendered lines as well. Because of their tangled and twisted history with the healthcare system, medical and healthcare institutions are often spaces where black women never encounter respect and positive regard. Yet, despite the lack of respect black women have grown accustomed to receiving in their relationship with medicine, it remains an important value in their healthcare. For Tarana, Alicia, and Stacey, to be respected was to be understood, supported, and heard. Respect also includes obtaining consent when consent is required and in situations that do not require consent, respect for the patient still involves well-informed care. Black women also feel respected when they experience urgency on their behalf. It is in that moment when they know their quality of life matters. A simple task such as moving a woman from a crowded hallway communicates that her privacy, comfort, and dignity are respected by those caring for her. Respect is an important value in African American communities and family systems. Respect for the elderly, the sick, and shut-in undergird many black women's familial and spiritual caregiving practices. They seek this same respect from their care providers during their moments of need.

Calls for African American Women Patients

Call for self-advocacy

Tarana, Jemel, and Patrice call for black women be their own advocates when seeking healthcare across systems. Their experiences of mistreatment and their subsequent process of making meaning and healing from their experiences illumined their sense of self-advocacy in

difficult and desperate moments. Tarana saw self-advocacy as speaking up about patient concerns, staying motivated to navigate the healthcare maze, and even entering into the healthcare field to transform the system from the inside out. Jemel declares, “I have my own best interest” in mind as a patient. For her, self-advocacy involves centering her own best interest and fighting for her needs. Patrice calls for black women to walk in boldness as they advocate for themselves. She attributes that boldness to divine favor, trusting that God provides her with authority over her own body. Tamika invites black women to feel empowered as they use their voice to speak up about their concerns. She urges African American women to speak up and out about their pain and hurt and to diligently seek the clinical support they need. Self-advocacy involves the patient being bold enough speak up and fight for her needs. It involves the patient feeling empowered to use her voice and to stay continuously motivated to keep showing up and seeking the care she needs.

Call for critical thinking

Opal urges black women *start asking questions*. She encourages them to be inquisitive about their care, to inquire about procedures, medications, and symptoms. She cautions that all black women must begin to advocate for themselves regardless of class or education. Opal sees asking questions with a sense of responsibility to herself and her community. Opal’s encouragement to ask questions highlights her call to critical thinking. Many research partners invited African American women to engage in critical thinking as they sought health care. Opal warns black women to not accept the status quo. She suggests an air of suspicion and critique is beneficial in the provider-patient relationship. Similarly, Patrice declares, “You don’t have to take what they’re giving you.” Like Opal, Patrice invites black women patients to ask questions and make informed decisions based on their own experience and intuition. Patrice believes care

providers can often be trusted, but in her experience of mistreatment, she found herself in opposition with the paramedic's interpretation of her symptoms. She now trusts that she is the expert of her own body and urges other black women to do the same. Jemel's call for critical thinking shows up in her invitation for African American women to know their patient rights. Jemel found her patient rights literally hanging on the hospital wall. She took the time to read and understand her rights, realizing she may have had to invoke them during the course of her hospitalization. Engaging in critical thinking for Opal, Patrice, and Jemel means being resourceful, skillful, and inquisitive in navigating their provider-patient and system-patient relationships. Critical thinking helps African American women to know who and what to trust and what resources to locate when safety is threatened.

Call for community engagement

An unexpected call that emerged from the interviews pertained to women's involvement with their community in ways that subvert how they were once treated. Meena shared that she dreams of bringing accessible holistic health practices such as yoga and reiki to African American communities. She hopes to bridge a wide gap between black communities and the holistic practices she found beneficial to treating her depression. Within these accessible practices, Meena hopes to provide the gift of hospitality and cultural compassion that she sought from the reiki studio. Alicia shared about her work with the National MS Society as a result of her frustrating experiences. She now aims to be a voice and face for African Americans with multiple sclerosis, a face and voice she so desperately needed when searching for a diagnosis. She hopes that her presence, her advocacy, and her voice empower others on their journeys with disability. Jemel, a doctoral student in social ethics, left her hospitalization motivated to change how the mental health field embodies their ethics and treats patients of color. Her experience

sparked determination to transform the system from not only the halls of hospitals but from the halls of the academy, too. Tamika designed a nonprofit organization equipped with support groups, coaching, and crisis hotlines for patients newly diagnosed with chronic illnesses. Throughout her journey with kidney disease and other medical complications, Tamika often felt she had nowhere to turn that spoke directly to *her* values of spirituality, self-advocacy, and empowerment – so she chose to create a space herself. Community engagement emerged as a call for African American women patients to find ways to create what they otherwise could not find in their health’s care. Their involvement in or dreams for their communities result from their experiences of mistreatment. The women took experiences of underrepresentation, limited support, and inhospitality and dreamed up ways to prevent those experiences from happening to others. Black women can use their experiences of suffering to light pathways for healing for others.

Call for building relationships with care providers

Developing relationships with care providers emerged as important for both educational and survival purposes. Although Tarana chose not to inform the nurse practitioner that she offended her by commenting on her cannabis use, as she reflects on her care encounter, she suggests taking the time to have conversations with care providers when they offend. If we refrain from holding these conversations, the providers may never learn when their actions are offensive. For Tarana, having difficult conversations with care providers could potentially disrupt future mistreatment. Similarly, because Alicia’s diagnosis of multiple sclerosis is a chronic illness, she has maintained sustained relationships with the same providers over the course of a decade and a half. She finds that she intentionally fostered these relationships because it became necessary for her to teach her care providers how to treat her as an African

American multiple sclerosis patient. Overtime, she developed trust and mutuality with her providers. She has had many difficult conversations with her care providers over the course of her treatment and values these relationships as a part of her identity as a patient. Likewise, Patrice passionately encourages African American women to find and form relationships with trusted medical providers, particularly women of color. She recognizes that access to preferred physicians is a privilege many black women may not have. However, Patrice feels having providers to rely on at various moments of a woman's health journey could mean the difference between life and death. She notes, "As much as you can, try to always have a second opinion ready to go."

The call to foster conversations and relationships with care providers allows for patients to speak directly to the care provider to share their concerns, ask questions, and if needed, provide education. I caution, however, that African American women are often placed in the position of educator representative of entire black communities. This extra tax to educate in the midst of clinical treatment is unnecessary and unjust. Black women should not feel obligated to educate care providers in the midst of their own suffering. Likewise, care providers must not expect suffering patients to design and teach cultural competency curriculum while seeking clinical care.

The women's calls beckon responses. On call-and-response discourse, Collins further writes, "The fundamental requirement of this interactive network is active participation of all individuals. For ideas to be tested and validated, everyone in the group must participate."²¹⁵ In centering the dialogical communication of African American culture, the women's calls invite communicative responses from other active participants within the healthcare system, namely

²¹⁵ Collins, *Black Feminist Thought*, 261.

providers and other African American women patients. This call-and-response discourse relies on listeners actively responding to living human narratives. As both a clinical chaplain and at times a patient, I imagined how I could best respond to the calls of Alicia, Stacey, Tamika, Opal, Tarana, Patrice, Jemel, and Meena each brought forth through their womanist psychospirituality. My question of response took me on a journey deep into the world of black birthwork.

Responding to Living Human Narratives

In the spirit of African American cultural call-and-response discourse mode, each woman summarized a *call-for-response* within her narrative. Their calls were to providers, asking them for trust, hospitality, engagement, and respect. Their calls were for other African American women to practice self-advocacy, critical thinking, community engagement, and relationship building with medical professionals. Each call warrants a response by those participating in the care of black women and black women patients as well.

Black Birthwork

The cultural-communal-spiritual practice of black birthwork as a *response* spoke to me as a womanist pastoral theologian and researcher, clinical chaplain, and African American woman patient. Birthworkers center the lived experience of the person in labor and provide unrelenting and fully embodied emotional and spiritual support. I use the term birthworker and doula interchangeably, recognizing that the term doula, meaning “servant-girl” in Greek, holds negative connotations for African American women. The term birthwork also encompasses more than doulas to include all those who support birthing people and their families before, during, and after labor. In *Battling Over Birth: Black Women Birthing Justice*, the authors describe doulas, particularly in the African American context, as:

non-medically trained birth assistants who provide emotional support, help with comfort measures to relieve pain, provide continuous reassurance and support during labor, help

mothers to be aware of and advocate for their birth choices, advocate for the birthing person and facilitate communication between mother and medical professional, and provide pre- and postpartum care.²¹⁶

Doulas, birthing companions, or birthworkers, mitigate mistreatment. Doula-assisted births increase the possibility of normal physiologic birth, decrease risks of complications in birth, and mothers are less likely to have negative feelings about their birth experiences.²¹⁷

Black birthwork in particular is an indigenous and deeply cultural approach to black women and their families and black birthworkers provide advocacy, support, and education for along perinatal journeys. Beginning on slave plantations, black birthworkers, or “granny midwives,” much like those blamed in Anarcha’s story, were often the only form of culturally relevant and safe healthcare support for African American women birthing their families. Their work was rooted in traditional West African cultures and spiritualities that integrated rootwork with faith.²¹⁸ The role of the black midwife and trained birthworker in African American and white families persisted heavily until the mid-twentieth century. Desegregation in the healthcare workforce forced black midwives to acquire expensive certifications in order to continue their work in modernized healthcare systems. The field of midwifery then transformed to a skilled nursing practice unobtainable to many poor African American women. However, black birthworkers, in the form of licensed midwives, doulas, lactation educators, and childbirth educators, continue to work in African American communities educated in the same paradigms of the “granny midwives” of times past.²¹⁹ It was these black birthworkers who lobbied during the pandemic to get New York Governor Andrew Cuomo to sign legislation allowing birthing

²¹⁶ Julia Chinyere Oparah et al., *Battling Over Birth: Black Women and the Maternal Health Crisis* (Texas: Praeclarus Press, 2018), 136.

²¹⁷ Oparah et al., *Battling Over Birth*, 137.

²¹⁸ Oparah et al., *Battling Over Birth*, 46.

²¹⁹ Oparah et al., *Battling Over Birth*, 46.

companions to enter New York State hospitals in response to the original policies prohibiting them.

The role of the black birthworker is to center the lived experience of the black woman in their care. Their expertise is the culturally relevant, emotional and spiritual support of black women. As companions in clinical spaces, black birthworkers center and advocate for their clients' spiritualities, value systems, and ancestral knowledge to be present and valued in their birthing spaces. Black birthworkers' methodological approach in centering black women in their care appeals to womanist pastoral theology. Care begins with the black woman's lived experience of pregnancy and her spirituality and cultural values are integrated into her care plan throughout her pregnancy and birthing experience.

Black birthworkers work in healthcare spaces tending to their patients' physical care in tandem with providing emotional and spiritual support. As non-medical professionals, birthworkers such as doulas offer forms of pain relief that are both spiritual and communal in nature, often involving touch, herbs, and prayer. As a clinical chaplain trained in the formal tradition of CPE, I believe black birthwork appeals to a subversive form of spiritual companionship alongside African American women. This indigenous form of spiritual companionship ensures their cultural particularities are tended to in the midst of the clinical healthcare space. As providers and companions, black birthworkers practice trust, hospitality, engage their assumptions, and respect the black women in their care. They also advocate for other care providers to do the same.

As an African American woman engaged in this critical narrative research process, the role of the black birthworker appealed to my sense of being a patient and seeing the importance of an advocate and companion in the midst of my wilderness in the healthcare system. I also

listened to Patrice speak to what her doula represented as a birthing support person during her pregnancy and delivery. I listened to Opal speak about her obstetrician, a black woman, who served as her advocate and companion in life-saving ways. Doulas and black birthworkers empower women to practice self-advocacy, critical thinking, and relationship building whether between doula and client, or facilitating improved relationships between their client and other care providers. Black birthwork is a form of spiritual care that integrates spirituality with healthcare in ways that mitigate mistreatment and support not only black women's flourishing, but the flourishing of her future generation.

Being Made and Unmade

It was Patrice's interview that reminded me of doulas. I remembered how I used to play with the image of pastoral caregiver as midwife and shaman, and how I learned about doulas when I became a clinical chaplain. I began to envision and research the role of a doula. When I first introduced to the work, I learned about international training classes, expensive certification fees, and no contextualization in diverse birthing experiences. When I reentered my exploration of the doula world from the perspective of reproductive justice, clinical mistreatment, and self-advocacy, I learned about black birthwork and dove into the work.

Patrice's comment on doulas opened up this entire exploration. It also opened up my decision to pursue a community-based doula training for African Americans in the Inland Empire cities of California. I stumbled upon the virtual community-doula training by chance, applied for the opportunity to be a part of the training, and within a week was accepted and began training. As I participated in the training, I found several overlaps in the clinical pastoral training and practice I engage as a chaplain as the primary objective for doulas is to provide spiritual and emotional support. The overlap and opportunity to engage in this work drew me to

believe that African American birthwork is spiritual care and particularly operates in the contextual clinical pastoral paradigm. Birthwork also holds wisdom for interrupting black women's mistreatment in maternal healthcare and the healthcare system in general.

Birthwork is Spiritual Care

Interrupting mistreatment in black maternal healthcare naturally occurs in the sacred practices of birthwork. Because black birthwork is birthed by black women, for black women, with the intent of providing appropriate holistic care for the survival of black women and their families, I argue that black birthwork is womanist clinical spiritual care. Therefore, a pastoral theological response to mistreatment in black maternal healthcare invites pastoral theology to embrace the field of black birthwork as a culturally relevant, culturally nonviolent, and indigenously black practice of spiritual care that can mitigate mistreatment among African American birthing people. I am careful to title this section, "Birthwork *is* Spiritual Care" as opposed to birthwork *as* spiritual care. I aim to not construct another metaphor for pastoral care. However, I am claiming that the clinical practice of birthwork is a form of pastoral or spiritual care.

Karen B. Montagno's essay, "Midwives and Holy Subversives: Resisting Oppression and Attending to the Birth of Wholeness," provides a theological image for birthwork *as* spiritual care. In Exodus 1, the king of Egypt instructed Hebrew midwives, Shiphrah and Puah, to murder the male infants they helped deliver to Hebrew mothers. However, based on their faithfulness to God and their people, they resist the king's instruction, thus saving the lives of many.²²⁰ Montagno identifies three notable themes within the story that contribute to her understanding of spiritual care: agency, teamwork, and collective resources as "the women 'act' against the

²²⁰ Exodus 1:11a, 12-17b (NRSV).

powers of the world (the king) because of their fear (or taking seriously the call) of God.”²²¹ The Hebrew midwives work within a context of urgency and peril for the health and safety of their people. This work is subversive as the women “interrupt and dismantle oppression and to ensure the wholeness and future of their communities.”²²² Shiphrah and Puah are midwives who model commitment to the wholeness of careseekers. Montagno views this as an invitation to contemporary spiritual care providers to the subversive work of resisting oppression while midwifing the birth of hope and healing within marginalized communities and suffering people. I see this as a testament to how birthwork is already situated in Judeo-Christo theological canon as spiritual care.

Through diving into birthwork, I find that the womanist healthcare values of trust, respect, critical thinking, and hospitality significantly align with the work of black birthworkers. They operate out of urgency and peril that considers the African American woman and her family. Much like Shiphrah and Puah, they sit with women in labor, in their vulnerability, and provide safety, advocacy, and a dignified birthing space. I imagine, birthworkers can also sit with other African American women patients within the clinical context and provide similar support. While support such as patient advocacy mirrors clinical chaplaincy, black birthworkers operate in a contextual clinical pastoral paradigm. While the birthing persons’ families are often involved, black birthworkers specifically listen to and center the lived experiences of African American women and work with the hermeneutic of cultural transference-countertransference and connect systems of privilege and power with feelings of powerlessness and despair. They do so by advocating for African American women in white healthcare spaces and monitoring power

²²¹ Montagno, “Midwives and Holy Subversives,” 7.

²²² Montagno, “Midwives and Holy Subversives,” 8.

dynamics at play. Birthworkers are specialists in the womanist psychospirituality of African American women and work directly with women's resiliency. They contribute to the survival rate of African American women who are far too often dying in labor. Like Shiphrah and Puah provided spiritual care to interrupt mistreatment in their community, black birthworkers provide spiritual care to interrupt the mistreatment of African American women in the healthcare system.

Summary and Next Steps

In the final chapter of their text, Jackson and Mazzei write, "What we weren't anticipating was the extent to which this embedded/embodied-ness would occur in the way that theory and data constituted us, and how in the threshold, the divisions among writing, thinking, data, participants, and research selves collapsed."²²³ As I conclude this narrative research, I hold Jackson and Mazzei's sentiment. Listening to and interpreting living human narratives through this critical research process inspired me to become a trained doula, trained specifically in the indigenous tradition of "granny midwives" of the past. I sought a theological response to mistreatment and found birthwork to align with both the contextual clinical pastoral paradigm and practices of interruption.

²²³ Jackson and Mazzei, *Thinking with Theory*, 137.

CHAPTER 9

SUMMARY AND NEXT STEPS

This dissertation attempts to listen, interpret, and respond to the living human narratives of African American women mistreated within the U.S. healthcare system. I constructed a contextual clinical pastoral paradigm and employed critical narrative research to engage the narratives of eight Southern Californian black women who not only carried stories of pain and violation but worked to theologically process their stories through meaning making. The methodology for this dissertation involved layered processes of narrative collection and narrative analysis that integrated contextualized theoretical concepts with lived human experience. Emerging from this research project are new ways of listening to African American women through collective boundary setting and cultivating storied spaces, new ways of interpreting their lived experience through psychoanalytical hermeneutics, and new ways of responding to African American women through black indigenous birthwork. This final chapter revisits the women's narratives and summarizes the dissertation's key contributions to the field of pastoral theology, and finally provides next steps to center the interruption of mistreatment among African American women in U.S. healthcare.

Living Human Narratives

Alicia received a delayed diagnosis of multiple sclerosis because her physician insisted that "black women don't get MS." She went months without being sure of her condition and learned to advocate for herself and educate her care team in order to finally receive appropriate

care. Through her journey Alicia found a sense of activism and community engagement that allows her to be a voice for other black women who *do* get MS.

Stacey told two stories, both of misdiagnoses. In seventh grade, she was suspected to have mononucleosis and accused by her physician of kissing boys. In fact, she had strep throat, and had never kissed anyone. In her adulthood she was misdiagnosed with hemorrhoids and quickly shooed out of the physician's office. With a different physician, she was correctly diagnosed with the chronic condition of irritable bowel syndrome. Stacey's experiences, especially the one in her youth, influenced how she and her family participate in the healthcare system today. As she thinks through her ideal healthcare team, she imagines a comforting presence such as the one God provides.

Tamika left the hospital against medical advice because she was fed up with her care. She suspected her attending physician to be intoxicated and over the course of her hospitalization, Tamika was accused of lying about the medications she was provided. Having gone into the hospital for breathing issues, Tamika felt her issues were never addressed. The attending physician chose to focus only on Tamika's underlying kidney issues rather than her presenting concern. Once she left the hospital, Tamika found a chiropractor who attended to her needs and alleviated her breathing issues within one visit. This experience encouraged Tamika to advocate for herself within the healthcare system as well as others navigating healthcare with chronic illness. To carry out her advocacy work, Tamika began her own nonprofit ministry for people with chronic illness.

Opal's labor and delivery at the military hospital was anything but ideal. Mishaps in the placement of both her epidural and her catheter caused Opal excruciating pain that was never acknowledged. During labor, her physicians switched shifts and she had to meet a new doctor

right as she was starting to push. Following the delivery of her first child, Opal hoped to learn how to breastfeed her baby girl, but received no lactation support during her hospitalization. Even more, Opal experienced extreme swelling her legs and when she brought this to her physician's attention they ignored her concerns and discharged Opal and her daughter that day. Opal believes God witnessed her mistreatment and intervened. A friend and black obstetrician provided Opal's care for her second child and Opal credits her new obstetrician for interrupting her mistreatment.

Tarana went to her local Planned Parenthood for birth control and left feeling misjudged for smoking marijuana. She also described disclosing her cannabis use and feeling labeled as a deviant member of society by her provider's verbal and nonverbal responses. Tarana smokes marijuana for mental health relief as she lives with PTSD and lacks health insurance for more traditional treatment. Her experience with this provider at Planned Parenthood limited her desire to want to engage with the community clinic any further. She felt judged for personal decisions that held no relation to her visit for birth control. Tarana learned to self-advocate and learned the importance of speaking on feelings of prejudice and discrimination within the healthcare space.

Patrice called the ambulance due to pain and excessive blood loss during a miscarriage. One of her paramedics assessed Patrice and relayed his assessment to the hospital over the phone as they made their way there. As he relayed his assessment, the paramedic downplayed what Patrice told him about her pain and her blood loss. Patrice, a young mother in the midst of terrifying and painful miscarriage, felt dismissed, gaslighted, and asked herself, "am *I* crazy?" As she reflects on her mistreatment, Patrice feels the divine throughout her experience and describes God as intervening on her behalf. The divine also encouraged and *emboldened* Patrice to

advocate for herself within healthcare spaces and be assured of her own body knowledge as she seeks medical care.

Jemel spent days in-patient at a local behavioral health hospital. The mistreatment Jemel experienced included a misdiagnosis of hepatitis B, not being provided with meals according to her dietary restrictions, and being threatened with a California welfare and institutions code of involuntary hospitalization for asking too many questions. The staff witnessed her sexual harassment and stood by unengaged. She waited hours for proper attire and felt inappropriately exposed. Jemel's process of meaning making is full of questions for the divine. She wonders why God let her endure mistreatment and not intervene. Jemel's experience produced a confidence to self-advocate in healthcare spaces and she urges others to know their rights and be prepared to fight for them.

Meena's encounter with mistreatment and discrimination in a reiki studio explores healthcare systems outside the American medical complex. Meena prefers holistic health practices such as reiki and yoga for both her mental and physical health. Meena felt racially profiled as soon as she entered into this San Diego reiki studio. She notes the staff's inhospitality and unwelcoming demeanor and remembers feeling watched as she looked through their merchandise. Meena, a reiki and yoga practitioner herself, follows the principles of *namaste* in her practice. She grieves spaces, like the reiki studio she visited, who publicly claim to practice the principles of *namaste* but treat black women differently due to stereotypes and prejudice. Meena hopes to create spaces for people of color to access holistic healthcare practices outside of the white gaze.

Black women's desires for wellness inspire them to find care in reiki studios and emergency behavioral health facilities when we need tools to manage depression, but

discrimination and sexual harassment exacerbate their mental stress. Their desires to survive prompt them to call paramedics for extreme blood loss from miscarriages and allergic reactions to medications, but what we say about our bodies – what we know about their bodies – is passed over as insignificant and untrustworthy. Their desires for health send them to clinics with confusing and painful symptoms and has them begging for answers for symptoms that we know are not supposed to be there, but we are rushed away with only scribbles of pointless or inaccessible prescriptions and sometimes with nothing at all. Their desires to flourish leads them to Planned Parenthood for birth control, only to leave feeling shamed and criticized for things that bore no weight on their presenting concern; and finding neonatal care through whatever means necessary, even if that means having a needle stuck in their spine three times and having a catheter *jammed* up their urethra.

Black women do seek treatment. But, we are mistreated when we do. Controlling images of African American women patients invade healthcare systems and dictate treatment during clinical encounters. Cultural transference and cultural countertransference interact within a care dyad causing African American women to feel mistreated. Their mistreatment, however, does not mean they therefore avoid seeking medical treatment, surrendering their health to disease and disparity. Their womanist psychospirituality helps them to make meanings out of their experiences and reengage the healthcare system when they need support, with tools and resources to navigate the system based on their values as African American women rooted in spiritualities, self-advocacy, and communities.

Key Contributions: Method and Theory

A New Paradigm: Contextual Clinical Pastoral Care and Living Human Narratives

Anton Boisen's living human document symbolizes the clinical pastoral paradigm and the theological exploration of lived human experience through religion and psychology. Living human documents are meant to be listened to within an individualized counseling setting, their stories written up as a "verbatim" and their words decoded through psychological and theological interpretation. The pastoral caregiver attempts to make meaning out of lived experience and when successful responds with theological insight to liberate one from spiritual bondage. I chose to rather privilege the oral-epistemology of African American women and construct a metaphorical image of living human narratives. This image symbolizes a contextual clinical pastoral paradigm that centers the individual clinical setting and interprets lived human experience through contextualized psychologies and theologies. The response is not to liberate from spiritual bondage, but rather to reimagine the systems of injustice – such as healthcare – in ways that contribute to the flourishing of African American women and their families.

The contextuality of this paradigm for the purpose of this project refers to womanist clinical pastoral care. Bonnie J. Miller-McLemore's living human web juxtaposes Boisen's documents by insisting on a feminist communal contextual paradigm that privileges communities over individual clinical spaces and considers social systems in the interpretation of lived human experience. This womanist clinical pastoral paradigm identifies the clinical dyad as a community of care and values the integration of social analysis with contextual psychologies and theologies such as womanist psychology and theology. I situate this paradigm along the continuum of womanist pastoral theologies searching for a balance of psychoanalysis, theology, and social analysis within their methods for interpreting black women's lives. Phillis Sheppard and

Stephanie Crumpton model this psychoanalytical and theological intersection and I hope to add this womanist clinical pastoral paradigm to their conversation.

Furthermore, I hope to contribute a womanist pastoral theological voice to the mistreatment of African American women within the healthcare system. Boisen's foundational focus of living human documents and the language worlds of patients in complex medical systems situates pastoral theology as an ideal methodological and philosophical space for the exploration of lived human experience within American healthcare systems. African American women intricately link their healthcare with their spiritual care and advocating for the just healthcare for African American women is caring for their spirits and their whole selves. The field of pastoral theology in general and womanist pastoral theology in particular must apply our tools of theological exploration, caring, and counseling to black women's healthcare. Black women's healthcare is spirit care, but black women's healthcare is failing. To care for the spirits and lives of black women is to ensure the healthcare system cares for them too.

Critical Narrative Research

Any response to address and interrupt mistreatment must begin with the stories of the mistreated themselves. To practically engage the eight women's stories, I employed a critical narrative research method that held three epistemological starting points. First, rooted in reproductive justice theory, African American women's knowledge about their bodies and their experiences must be believed and they must be trusted as capable decision-makers about their bodies. Second, rooted in black feminist standpoint theory, African American women's lived experience and knowledge holds privileged wisdom for critiquing and reimagining healthcare systems. Third, African ancestral oral-epistemology iterates that African American women produce knowledge through storytelling. In approaching this narrative research inquiry with

these epistemological starting points, I departed from traditional methodologies in narrative collection and narrative analysis. These starting points contribute to conducting culturally relevant and culturally compassionate narrative collection and analysis with African American women sharing complex and difficult stories of mistreatment. These starting points encouraged my research partners' authority and control in telling their own stories how they wanted and being believed when they did.

*Narrative Collection: Collective Boundary Setting,
Interviewing, and Storied Space*

I utilized the qualitative research interview to collect the women's living human narratives. I met with two women, Alicia and Jemel, in person, and the other six women through video due to the start of the COVID-19 pandemic. With intention, the interview space became a *storied* space where Alicia, Stacey, Opal, Patrice, Jemel, Tarana, Tamika, and Meena could speak aloud both their narratives of mistreatment and meaning making. At the beginning of each interview, my research partners and I collectively set boundaries for our interview. Collective boundary setting describes a set of questions intended to boundary the interview to mitigate emotional harm. Collective boundary setting encouraged my research partners to take part in the flow of the interview, assisted in preventing re-traumatization, and demonstrated my respect for my research partners' emotional limitations during the pandemic. Following our collective boundary setting, I asked each woman the same set of questions to capture her narrative of mistreatment and narrative of meaning making. These interviews were audio-recorded, transcribed, and analyzed. This narrative collection process is the listening method of the contextual clinical pastoral paradigm.

Narrative Analysis: Coding and Thinking with Theory

The first narrative analysis method engaged was coding. Codes were identified within the women's narratives of mistreatment and narratives of meaning making. While codes assisted in exploring research questions, by utilizing Jackson and Mazzei's qualitative data analysis process of *thinking with theory*, I plugged "data into theory into data" to see what new knowledge emerged from the process.²²⁴ This data analysis process of coding and thinking with theory served as the interpretation method of the contextual clinical pastoral paradigm.

Within narratives of mistreatment, I identified the codes suspicion, dismissiveness, apathy, bias performance, disrespect, and stereotyping. These codes helped to address the research question, *what occurs within the clinical care encounter leaving African American women with a story of mistreatment?* I drew from metatheory in transference and cultural countertransference to develop a psychoanalytical hermeneutic of culture to further explore how the narratives unpack this question. This hermeneutic of culture involves analyzing subconscious, culturally-rooted relational behavior of both the patient and the provider. In my research partners' narratives of mistreatment, I used this hermeneutic to identify both cultural transference and cultural countertransference within the care dyad.

Cultural transference describes the patient holding knowledge of the long history of mistreatment with African American women, her past personal experiences of mistreatment, and her present embodied experience all within the clinical encounter. Cultural countertransference describes clinicians' permanent and subconscious cultural positionalities, values, and assumptions about the careseeker that informs their caregiving relationships. Each woman's narrative demonstrated both cultural transference and countertransference at work, causing the

²²⁴ Jackson and Mazzei, *Thinking with Theory*, 13.

women to leave their care encounters feeling mistreated. Through thinking with theories of cultural transference and countertransference the narratives of mistreatment opened up to suggest that the women hold significant knowledge of historical mistreatment in U.S. healthcare and have experienced mistreatment throughout the course of their lives. The narratives also suggest that socially constructed and controlling images of African American women patients significantly influence the women's treatment in the healthcare system.

Within narratives of meaning making, I identified the codes trust, respect, hospitality, awareness of assumptions, living out beliefs, divine intervention, self-advocacy, relationship building, and critical thinking. These codes addressed the research question, *how do black women make meaning out of their mistreatment in order to maintain their resilience and continued reliance on the healthcare system?* I constructed a hermeneutic of psychospirituality to better explore this research question in light of the codes I identified. This womanist psychospirituality is a confluence of metatheory, method, and assessment in African American psychology, womanist psychology, and womanist theology. Womanist psychospirituality describes black women's emotional and cognitive processes of meaning making and healing for both themselves and their communities in light of psychological, social, and political challenges. African American women possess significant resilience in light of interlocking oppressions. The narratives of meaning making opened up how this sense resilience emerged for my research partners as they reflect on their mistreatment.

In interweaving the interview data with African American and womanist psychologies with womanist theology, three major themes of womanist psychospirituality emerged. *Spirituality as coping* emerged as a way for the women to positively cope with experiences of racism or sexism within their healthcare encounter. They relied on their spiritualities to assist in

processing mistreatment. *Spirituality and healthcare values* emerged as the women connected their healthcare treatment to their spiritual values. Their spiritualities guide how they would like to be treated in their everyday lives and therefore within the healthcare systems they must rely on every day. Finally, the concept of *wilderness-experiences* and *making a way out of no way* emerged as the women spoke of divine intervention within their healthcare treatment. At times, God intervened to interrupt mistreatment by transforming the women's self-confidence or placing a helpful provider in their lives. And at times, God was expected to intervene but did not, leaving the woman to navigate the wilderness of mistreatment on her own.

Jackson and Mazzei posit that researchers engaging in the process of thinking with theory will be "made and unmade" throughout their research as data and theory are plugged into one another, pushed to their limits, and new concepts and frameworks emerge.²²⁵ I found myself being made and unmade throughout this research process as I worked through identifying how pastoral theology and black women's healthcare meet.

Next steps

Birthwork is Spiritual Care

In the spirit of African American cultural call-and-response discourse mode, each woman summarized a *call-for-response* within her narrative. Their calls were to providers, asking them for trust, hospitality, engagement, and respect. Their calls were for other African American women to practice self-advocacy, critical thinking, community engagement, and relationship building with medical professionals. Black birthwork emerged as a womanist clinical pastoral theological method of caring for African American women within healthcare that responds to the

²²⁵ Jackson and Mazzei, *Thinking with Theory*, 137.

eight women's calls. Doulas and midwives have interrupted mistreatment among African American birthing people for generations and continue to do so in their efforts to alleviate the black maternal mortality rate. If applied across the lifespan, the role of the black birthworker within clinical spaces has the potential to interrupt mistreatment for all African American women for generations to come. I became a black community trained doula to understand and participate in this indigenous spiritual care model of African American women. I look forward to expanding and integrating my clinical practices of black birthwork and clinical chaplaincy in ways that support the health and healthcare of black women patients.

Theologically trained birthworkers exist and our practices must not be appropriated by those disconnected from the work. Rather, this is a welcoming invitation to view birthwork as a form of spiritual care that mitigates mistreatment and that can be employed through the use of womanist clinical pastoral theology in order to assist in interrupting black women's mistreatment. Integrating the study and practice of birthwork into pastoral theology and care improves healthcare outcomes of African American women by integrating contextual clinical pastoral paradigm of pastoral care and counseling with the rich and evidence-based care practices of birthwork. Pastoral theology can participate in ensuring the survival of black women by welcoming the world of black birthwork and advancing the field through application of pastoral theological theory and research methods.

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APPENDICES

Appendix A

Recruitment for Participation Flyer

A recruitment flyer with a red and pink geometric background. The title '[MISS]TREATED' is in large, bold, black letters. Below it, a subtitle reads 'A WOMANIST CLINICAL PASTORAL THEOLOGY ON THE MISTREATMENT OF AFRICAN AMERICAN WOMEN IN THE AMERICAN HEALTHCARE SYSTEM'. The flyer is divided into two main columns of text. The left column discusses the mistreatment of African American women in childbirth and the need to tell their stories. The right column defines mistreatment as harmful behaviors or actions, medical or otherwise, that demonstrate a lack of respect, dignity, or trust. A contact box at the bottom left invites people to contact dissertation researcher Jessica R. Chapman. A small IRB number is at the bottom right.

[MISS]TREATED

A WOMANIST CLINICAL PASTORAL THEOLOGY ON THE MISTREATMENT OF AFRICAN AMERICAN WOMEN IN THE AMERICAN HEALTHCARE SYSTEM

AFRICAN AMERICAN WOMEN ARE 3 TIMES MORE LIKELY TO DIE IN CHILDBIRTH THAN WHITE WOMEN AND AN OVERWHELMING MAJORITY OF RESEARCH PROVES THIS EPIDEMIC IS LARGELY DUE TO DISCRIMINATION BY THE HEALTHCARE SYSTEM. BUT, MATERNAL MORTALITY IS NOT THE ONLY WAY AFRICAN AMERICAN WOMEN ARE MISTREATED IN THE AMERICAN HEALTHCARE SYSTEM. IT'S TIME WE TELL OUR STORIES OF MISTREATMENT.

MISTREATMENT REFERS TO HARMFUL BEHAVIORS OR ACTIONS, MEDICAL OR OTHERWISE, THAT DEMONSTRATE A LACK OF RESPECT, DIGNITY, OR TRUST AS PERCEIVED BY THE WOMAN RECEIVING TREATMENT.

HAVE A STORY TO TELL? PLEASE CONSIDER CONTACTING DISSERTATION RESEARCHER JESSICA R. CHAPMAN AT [JESSICA.CHAPMAN@CST.EDU](mailto:jessica.chapman@cst.edu)

CLAREMONT SCHOOL OF THEOLOGY IRB #2019-1101

Appendix B

Consent to Participate in Dissertation Research

Identification of Investigator and Purpose of Study

You are invited to participate in a research study, entitled “*MissTreated: A Womanist Clinical Pastoral Theology on the Mistreatment of African American Women in the American Healthcare System.*” The research is led by Jessica R. Chapman, Ph.D. candidate at Claremont School of Theology in the area of Practical Theology: Spiritual Care and Counseling. This research will additionally be supervised by Claremont School of Theology’s Institutional Review Board and Jessica R. Chapman’s dissertation committee comprised of Dr. K. Samuel Lee (chair), Dr. Nicholas Grier, and Dr. Dionne Bensonsmith.

This project seeks to understand the narratives of mistreatment of African American women. The interview will center upon the interviewee’s experience of being mistreated as a patient within the American healthcare system. The research aims to listen to, assess, and theologically respond to the stories of clinical mistreatment perpetrated toward African American women who have been patients within the American healthcare system within the past ten years. The term patient refers to *a person receiving clinical treatment by professional clinicians including but not limited to physicians, nurses, mental health professionals, physical therapists, social workers, and dentists.* The term mistreatment refers to *harmful behaviors or actions, medical or otherwise, that demonstrate a lack of respect, dignity, or trust as perceived by the person receiving the treatment.* By telling your story of mistreatment, you contribute to the widening narrative of African American women harmed by the American healthcare system for generations. This dissertation argues that such mistreatment necessitates a womanist clinical theological response that begins to dismantle these embedded precedents of mistreatment and thus contributes to new paradigms of healing and flourishing for African American women patients.

You are free to contact the investigator or committee chair using the information below to discuss the study:

Jessica R. Chapman, Investigator
Phone: (619) 972-9963
Email: jessica.chapman@cst.edu

K. Samuel Lee, Ph.D., Chair
Phone: (909) 447-6331
Email: slee@cst.edu

The Interview Process

- Interviewee requirements:
 - The participant must be 18 years or older.
 - The participant must self-identify as African American.
 - The participant must self-identify as a woman.
 - The participant must live within the Greater San Diego or Los Angeles areas.

- The participant must have been a *patient* within the American healthcare system within the past ten years (this project's definition of *patient* is located above).
- The participant must have experienced *mistreatment* while a patient within the American healthcare system (this project's definition of *mistreatment* is located above).
- The participant must not have been a patient of VITAS Healthcare or Kaiser Permanente Orange County within the past ten years.
- The individual interview will require approximately sixty to ninety minutes.
- The individual interview will be held at a mutually agreed upon confidential, quiet, and comfortable location.
- The group interview will require approximately ninety to 120 minutes.
- The group interview will be held at a geographically convenient location that is confidential, quiet, and comfortable such as a local church.
- The group interview will comprise of all individual interview participants (as available) and will focus on discussing common themes uncovered throughout the individual interview process as well as discussing how African American women make meaning of their experiences of mistreatment.
- If a participant is unable to attend the group interview, a second individual interview may take place.

The purpose of this study is to gain insight into practical theology and spiritual care. Participation in this study should not be regarded as – or substituted for – therapy by a licensed professional.

Risks/Benefits/Confidentiality of Data

All the processes of the interview are designed to create minimal risk for those participating in the research; however, there is possibility that the topic to be discussed will cause you to feel uncomfortable, sad, or anxious. If you wish to discontinue your participation you may do so at any time.

Your privacy will be protected. All personal information including your name and contact information will be treated as confidential. Your identity will not be publicly shared. Unedited interview data will be accessed only by the researcher of the study.

The entire interview process will be recorded with a digital audio recorder. The recording will be saved on the researcher's computer hard drive in a password protected file for transcription use. The digital recording files will be permanently deleted by May 31, 2025. The transcriptions of the interviews will be saved in Microsoft Word format in a password protected file on the researcher's computer hard drive. The researcher will be the only person or entity with access to the hard drive files.

The data collected throughout this dissertation project may be published or presented at an academic conference. However, neither the data nor the final contents of the research will contain any information that reveals your identity or personal information.

Participation or Withdrawal

Without any conditions, you can request the interview to stop and you can withdraw from participation in the research at any point of the process. At the time of your declaration of withdrawal, you can also request that any information gathered be destroyed. Also, the researcher may choose to terminate the interview process with you if you are considered to be an ineligible subject of the study.

Contacts

If you have any questions about the study or need to update your email address contact the primary investigator, Jessica R. Chapman, at (619) 972-9963 or send an email to jessica.chapman@cst.edu. You may also contact the advisor, K. Samuel Lee, at (909) 447-6331 and slee@cst.edu. This study has been reviewed by Claremont School of Theology Institutional Review Board and the study number is 2019-1101.

Questions about your rights as a research participant.

If you have questions about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the chair of the Institutional Review Board by email at irb@cst.edu.

Thank you.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form.

Name of Participant

Signature of Participant

Date

Address

Phone

Email

SIGNATURE OF INVESTIGATOR

Signature of Investigator

Date (same as participant's)

A copy of this document will be supplied for your records.